of Tennessee

JANUARY 2015

# BlueAlert℠

## BlueCross BlueShield of Tennessee, Inc.

(Articles apply to all lines of business unless stated otherwise)

CLINICAL

### Medical Policy updates/changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

**Effective Feb. 8, 2015**

- Complementary and Alternative Medicine
- Chromosomal Microarray Testing for Evaluation of Early Pregnancy Loss

**Effective Feb. 18, 2015**

- **Bevacizumab**
- **Pralatrexate**

**Note:** These effective dates also apply to BlueCare℠/TennCare*Select* pending State approval.

### Modified Utilization Management Guideline updates/changes

BlueCross BlueShield of Tennessee's website has been updated to reflect upcoming modifications to select Modified Utilization Management Guidelines. The *Modified Utilization Management Guidelines* can be viewed on the Utilization Management Web page at www.bcbst.com/providers/UM_Guidelines/.

**Effective Feb. 18, 2015**

The following guideline has been updated as it relates to inpatient and surgical care:

- *Transcatheter Permanent Occlusion or Embolization*

**Note:** These effective dates also apply to BlueCare/TennCare*Select* pending State approval.

### NEW New drugs added to commercial specialty pharmacy listing

Beginning Jan. 1, 2015, the following drugs have been added to our Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

**Provider-administered via medical benefit:**

- Iluvien
- Treanda (PA)

**Self-administered via pharmacy benefit:**

- Harvoni (PA)
- Hyqvia (PA)
- Ofev (PA)
- Esbriet (PA)

**Providers can obtain PA for:**

- Provider-administered drugs that have a valid HCPCS code by logging onto BlueAccess℠, the secure area of www.bcbst.com and select Service Center from the Main menu, followed by Authorization/Advance Determination Submission. Physicians not registered with BlueAccess or needing assistance using our website should contact eBusiness Solutions†.
- Provider-administered specialty drugs that do not have a valid HCPCS code by calling 1-800-924-7141.
- Self-administered specialty drugs by calling Express Scripts at 1-877-916-2271.

**Note:** BlueCross BlueShield of Tennessee updates its web authorization forms on a quarterly basis. If the HCPCS code is not available now, it may be in the near future.

### What's Changing on the Prescription Drug List?

Every year the Prescription Drug List is reviewed to determine changes based on a drug's effectiveness, safety and affordability. While many changes to the Prescription Drug List occur at the beginning of the year, formulary changes can occur at any time because of market changes such as:

- Release of new drugs to the market after FDA approval
- Removal of drugs from the market by the FDA
- Release of new generic drugs to the market

The 2015 Prescription Drug List is available on our website at www.bcbst.com/docs/pharmacy/2015_Whats_Changing_Prescription_Drug_List.pdf

ADMINISTRATIVE

### REMINDER: Electronic claim filing resources

Beginning Jan. 1, 2015, we will begin executing the July 2013 electronic claims filing requirement pursuant to the BlueCross Minimum Practitioner Network Participation Criteria. To help providers achieve compliance with this requirement, BlueCross has several resources available to assist providers in making the transition to a fully-electronic submission environment:

**Corrected/Secondary Claims** – BlueCross accepts corrected and secondary claims electronically for institutional, professional, and dental claim types.

- **Corrected Claims:** www.bcbst.com/providers/ecomm/bcbst_5010/5010_Corrected_Claims.pdf

- **Secondary Claims:** www.bcbst.com/providers/ecomm/bcbst_5010/Electronic_Secondary_Claim_Guideline.pdf

**eBusiness User Guide** – Information on processes and reports used when filing EDI claims can be found here:

- **eBusiness User Guide:** www.bcbst.com/providers/ecomm/eBusiness%20User%20Companion%20Guide_04232013.pdf

NEW **Supplemental EDI Information** – A new technical guide has been created to assist providers that must file additional details on certain types of services that require invoice data, drug data, or any sort of additional documentation. Also covered in this guide is the new PWK process for submitting attachments for electronic claims:

- **Supplemental EDI Information:** www.bcbst.com/docs/providers/Supplemental-EDI-Information.pdf
- **PWK Fax Coversheet:** www.bcbst.com/docs/providers/PWK-Coversheet.pdf

As always, our eBusiness Support team is ready to answer any questions you may have about electronic claims filing, BlueAccess, or any other topic related to our electronic offerings. Please contact us at (423) 535-5717†, if you need any assistance.

## Have your patients received their flu shot?

The media recently released reports that this year's flu vaccine will have lessened effectiveness than past vaccines. Please remind your patients that, even with this being true, flu shots are still their best defense against the flu and will lessen symptoms if they do get the flu. Member benefit information for the flu shot can be verified by calling the appropriate BlueCross BlueShield of Tennessee or BlueCard Provider Service line†.

## IMPORTANT: TennCare drug safety alert to providers

The U.S. Food and Drug Administration (FDA) issued two (2) communications regarding a known safety concern with codeine use in certain children after tonsillectomy and/or adenoidectomy (surgery to remove the tonsils and/ or adenoids). (Please see FDA communications of Aug. 15, 2012, www.fda.gov/Drugs/DrugSafety/ucm313631.htm and Feb. 20, 2013, www.fda.gov/Drugs/DrugSafety/ucm339112.htm) .

The FDA is also conducting a safety review of codeine to determine if there are additional cases of inadvertent over dosage or death in children taking codeine, and if these adverse events occur during treatment of other kinds of pain, such as post-operative pain following other types of surgery or procedures.

### The Problem

Codeine is an opioid pain reliever narcotic analgesic medication used to treat mild to moderate pain. When codeine is ingested it is converted to morphine in the liver by an enzyme called cytochrome P450 2D6 (CYP2D6). Some people have DeoxyriboNucleic Acid (DNA) variations that make this enzyme more active, causing codeine to be converted to morphine faster and more completely than in other people. These "ultra-rapid metabolizers" are more likely to have higher than normal amounts of morphine in their blood after taking codeine. High levels of morphine can result in breathing difficulty, which may be fatal.

Some children may be at higher risk because of underlying diseases – having sleep apnea or other respiratory conditions. The estimated number of "ultra-rapid metabolizers" is 1 to 7 per 100 people, but may be as high as 28 per 100 people in some ethnic groups.

### Health Care Professionals

Health care professionals should be aware of the risks of using codeine in children. Health professionals should consider prescribing alternative analgesics for post-operative pain control in children. There are several very good alternatives. It is also important to emphasize that all drugs have risks. Health care professionals should always weigh the benefits versus the risks before prescribing any medication.

## REMINDER: Avoidance of antibiotic treatment in adults and children with respiratory conditions

BlueCross BlueShield of Tennessee is committed to providing physicians with important information that supports appropriate testing and antibiotic use. This quality improvement initiative focuses on the avoidance of antibiotic treatment in children and adults with the following respiratory conditions.

- Children (ages three (3) months to 18 years) with upper respiratory infection (URI)
- Children (ages two (2) to 18 years) with pharyngitis (CWP)
- Adults (ages 18 to 64 years) with acute bronchitis (AAB)

BlueCross would like to partner with our physicians on this important initiative. A team of BlueCross clinicians will be visiting various physician offices across the state to work collaboratively to improve quality measurements for antibiotic prescribing and decreasing antibiotic resistance.

Educational information to print and share with our Commercial, BlueCare Tennessee and CoverKids members is available on our company websites www.bcbst.com and bluecare.bcbst.com as well as on the Centers for Disease Control and Prevention (CDC) website at www.cdc.gov/getsmart.

## Coding requirements

When billing for services rendered to BlueAdvantage℠, BlueChoice (HMO)℠, BlueCare Tennessee or BlueCare Plus (HMO SNP)℠ members, providers should refer to the most current federal, state, or other payer instructions for specific requirements applicable to the CMS 1500 professional and CMS 1450 facility health insurance claim forms. Medical/clinical codes including diagnoses and modifiers should be reported in accordance with the governing coding organization. Failure to follow the referenced instructions may result in claim returns or payment denials. Please refer to your contract with these lines of business for coding and reimbursement specifics if applicable.

## Telemedicine Originating Site fee coding now available*

BlueCross BlueShield of Tennessee reimburses for services rendered via Telemedicine in accordance with Tennessee Telehealth mandate (TCA 56-7-10) effective Jan. 1, 2015. Qualifying codes for BlueCross Commercial and BlueAdvantage lines of business are consistent with The Centers for Medicare & Medicaid Services (CMS) and TennCare℠ guidance. By filing claims for encounters rendered via Telemedicine, providers are attesting that said claims were rendered according to these rules and guidelines. This reimbursement may not apply to certain self-funded groups if telemedicine is listed as a coverage exclusion in their contract.

Beginning Jan. 1, 2015, Commercial and BlueAdvantage Originating Site practitioners may bill and receive a $20 flat fee payment for Q3014 when the Originating Site practitioner is not affiliated with the Distant Site practitioner. For the Originating Site, code Q3014 is allowed for each qualifying unit of service received via Telemedicine for professional claims only.

For Distant Site practitioners, the qualifying encounter code should include a GT modifier to indicate the service was delivered via Telemedicine.

In the event that CMS designates a replacement code for Q3014 or establishes a fee for Q3014 or its replacement code, BlueCross will utilize that new code reimbursement to replace the current $20 flat fee.

> While it is acceptable to render services via Telemedicine from satellite to satellite as a convenience for multi-site providers (as indicated by a GT modifier), it is not appropriate to bill Q3014 under these circumstances.

Q3014 billing will be audited and dollars recouped for billing outside policy and/or billing when no corresponding GT encounter is on file for the date of service. Medicare guidance is available on their website at www.cms.gov/Medicare/Medicare-General-Information/Telehealth.

## Weight assessment and counseling for nutrition and physical activity for children and adolescents

Adults are not the only ones who need a fresh, healthy start to the new year. Childhood and adolescent obesity can unfortunately lead to negative health outcomes for life. Body Mass Index (BMI) percentile assessment and counseling for nutrition and physical activity is recommended yearly for children and adolescents 3 to 17 years of age to help keep them on track. Now is the perfect time to address weight and nutrition with your patients during their annual primary care physician (PCP) or OB/GYN visit. Here are some tips to make sure good nutrition and physical activity is part of the resolution for your patients and their parents:

- Discuss current nutritional status and activity behaviors.
- Provide nutritional and physical activity educational materials when necessary.
- Provide guidance for nutritional and physical activity recommendations.
- Consider weight or obesity counseling if necessary.

Completing these activities is an essential component of quality health care. Please remember to address these important topics with all your patients yearly. Early weight management interventions for children and adolescents will instill the positive behaviors needed for healthy outcomes as adults.

## REMINDER: Skilled nursing facilities that provide lab testing

Commercial, BlueCare and TennCare*Select* Skilled Nursing Facility (SNF) contracts reimburse facilities a per diem rate that includes routine laboratory testing. BlueCross BlueShield of Tennessee considers all Clinical Lab Improvement Amendments (CLIA)-waived lab procedures to be routine. CMS maintains a list of CLIA-waived procedures that can be referenced at the following link: www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/waivetbl.pdf

Non-routine lab procedures for Commercial members who are admitted to a contracted SNF should be billed by the contracted lab that performs the testing. Non-routine lab procedures for BlueCare and TennCare*Select* members who are admitted to a contracted SNF should be billed by the contracted lab if the tests are listed on the Quest Exclusion List. Non-routine BlueCare and TennCare*Select* lab procedures that are not listed on the exclusion list should be sent to Quest. The exclusion list is available online at bluecare.bcbst.com/forms/Provider%20Information/Quest_Diagnostics-Exclusion_list.pdf

* Contracted facilities should always use laboratories that are also contracted with BlueCross and/or BlueCare Tennessee.

# BlueCare Tennessee

**ADMINISTRATIVE**

## Prior authorization update for certain CPT® codes*

Beginning Feb. 1, 2015, the following CPT® codes will require prior authorization for BlueCare Tennessee members for Transcranial Magnetic Stimulation for Depression:

- 90867 - Therapeutic repetitive transcranial magnetic stimulation treatment; initial, including cortical mapping
- 90868 - Therapeutic repetitive transcranial magnetic stimulation treatment; sub delivery and management, per session
- 90869 - Therapeutic repetitive transcranial magnetic stimulation

## Welcome back Middle Grand Region providers

BlueCare Tennessee is excited to once again be serving TennCare members in the Middle Grand Region. TennCare members that were transitioned to BlueCare Tennessee were assigned on Jan. 1, 2015.

To help with any questions related to the transition of these members, along with other information, Frequently Asked Questions (FAQs) are available on the BlueCare Tennessee website at bluecare.bcbst.com/forms/BlueCare-Statewide/Providers/Provider-Transitioning-FAQs.pdf or you can contact the BlueCare Tennessee Provider Service Line†.

## Prior authorization fax numbers updated for behavioral health services*

Behavioral health services, including all levels of care for inpatient, outpatient, residential, and crisis stabilization prior authorization requests, should be submitted via fax to 1-866 320-3800. Requests for Provider Initiated Notices should be submitted via fax to 1-800-859-2922. Prior authorization requests for behavioral health services can also be obtained by calling 1-888-423-0131 for BlueCare and 1-800-711-4104 for TennCare*Select*.

Prior authorization requests for behavioral health service for CoverKids should continue to be submitted via fax to 1-800-851-2491 or by calling the Provider Service Line at 1-800-924-7141.

## Continued Focus on Improved Member Satisfaction and Care

BlueCare Tennessee Quality Improvement Programs continue to focus on improving the satisfaction and care that our BlueCare, TennCare*Select* and Cover Tennessee members receive from their doctors. The 2014 Adult CAHPS survey results indicate that BlueCare Tennessee providers are ranked below the 75th percentile nationally on questions related to how well doctors communicate.

The CAHPS survey tool measures our member's perception of your communication with them through a series of four questions:

- How often did your personal doctor explain things in a way that was easy to understand?
- How often did your personal doctor listen carefully to you?
- How often did your personal doctor show respect for what you had to say?
- How often did your personal doctor spend enough time with you?

According to an article published by the Agency for Healthcare Research and Quality titled, *Training to Advance Physician's Communication Skills*, communication can have a significant impact on health outcomes. This article cites a study conducted at the University of Kansas School of Medicine in Kansas City stating, "...patients' reports of their understanding of the post discharge information and instructions they had received was significantly less than what their doctors perceived. For example, while the physicians thought that 89 percent of the patients understood the potential side effects of their medications, only 57 percent of patients said that they understood."

At BlueCare Tennessee, we share your belief that doctor-patient communication is a key factor to better health for our members. We want to assist you in reinforcing the important information you share with members. We have many educational materials available for use in your office, and we can also assist individual members through our case management and patient education programs.

An article published on April 12, 2013 by the Wall Street Journal titled The Experts: *How to Improve Doctor-Patient Communication* offered some proactive measures you and your office team can take to make sure you are communicating with your patients. These familiar tips include:

- Look patients in the eye when talking with them
- Show empathy in your responses
- Improve your communication with fellow clinicians
- Listen more and talk less
- Be careful about making assumptions

Asking patients to "explain back" instructions they have just received is another helpful way to be sure communication has been effective. We know that many of our members have multiple chronic conditions, and our population health programs can help them to better understand their conditions and treatment plans. Please refer members to us that you identify as needing support.

In February 2015, BlueCare Tennessee will offer our members another opportunity to complete the CAHPS survey. Improving your communication skills now can significantly improve our member's perception of the care they receive from you.

Sources:

cahps.ahrq.gov/quality-improvement/improvement-guide/browse-interventions/Communication/Physicians-Comm-Training/index.html

online.wsj.com/articles/SB10001424127887324050304578411251805908228

## PCP Rate Bump Reminder for 2014

Effective Jan. 1, 2013, qualified Primary Care Physicians (PCPs), as detailed by CMS regulation, received a rate increase. This increase is also referred to as the "PCP Bump" and the "PCP Rate Enhancement Payment". In accordance with federal regulations the enhanced payments ended effective Dec. 31, 2014.

## REMINDER: Transition of contracting and credentialing for behavioral health providers

Beginning Jan. 1, 2015, BlueCare Tennessee assumed responsibility for behavioral health contracting and credentialing for the BlueCare, TennCare*Select*/CoverKids, and BlueCare Plus (HMO SNP)℠ networks. Our intent is to contract with providers directly under essentially the same terms and rates that existed with ValueOptions, Inc.

Please keep in mind these important dates:

- Early January – Members receive notification of provider's non-participating status if BlueCross did not receive a signed contract back from the provider.
- Jan. 1, 2015 – Earliest network effective date. Providers from whom a contract was not received will begin receiving reimbursement at out-of-network rates.

Contact your local Behavioral Health Provider Network Manager with any questions.

## REMINDER: Are you seeing your assigned members?

We all know how important it is for Primary Care Physicians (PCPs) to help coordinate our members' health care needs. As a BlueCare Tennessee PCP, it is your responsibility to verify any BlueCare/TennCare*Select* member you see is assigned to your patient listing or to another participating PCP in your group.

Additionally, be sure BlueCare Tennessee has your current on-call information. Should you need to update your information, complete the "Provider Change in Information Form" located on the BlueCare Tennessee website at bluecare.bcbst.com/forms/Provider%20Forms/Provider_Change_in_Information_Fax_Back.pdf and fax to (423) 535-5808.

# BlueCare Plus (HMO SNP)℠

## Primary Care Physician Member Roster

BlueCare Plus℠ offers a new Primary Care Physician (PCP) Member Roster available in BlueAccess at bluecareplus.bcbst.com. The report provides a listing of BlueCare Plus members for PCPs in the BlueCare Plus provider network. For questions, call our Provider Service Line†, or for technical assistance please call eBusiness Technical Support† at the phone numbers listed on the last page of this newsletter.

## Part B Hospice related services

Claims submitted for BlueCare Plus members enrolled in hospice will be denied if not submitted with either GV (attending physician not employed or paid under arrangement by the member's hospice provider) or GW modifier (service not related to the hospice patient's terminal condition). If you have any questions, please call the Provider Service Line†.

QUALITYCARE REWARDS

## Final data needed for the end of the Physician Quality Incentive Program

The measurement period of the 2014 Physician Quality Incentive Program ended on **Dec. 31, 2014**. To receive credit for measures closed in 2014 that apply to the Star Ratings calculation, be sure to submit all claims and self-reported information for 2014 to us by **Feb. 1, 2015**. Final payments, for outcome/adherence measures and the close-out of procedure-based measures, go out on **April 30, 2015**. For reimbursement details and dates, consult the Physician Quality Incentive Program: Dates to Remember document.

Gaps in care can be closed by submitting data through:

1. Claims coding (the most effective and direct approach)
2. The Pay for Performance web tool (which you can log into through BlueAccess)
3. Patient Assessment Forms (PAFs)
4. Paper attestation forms
5. Medical records

Details about ways to submit data can be found in the Data Submission Resource Guide. If you have any other questions about the Physician Quality Incentive Program, check the Quality Care Rewards webpage or the Quality Bonus Program Resources webpage. If you can't find the answer to your question on the website, please contact your local eBusiness marketer or the Service Center†.

*These changes will be included in the appropriate 1Q 2015 provider administration manual update. Until then, please use this communication to update your provider administration manual.

**Archived editions of BlueAlert are available online at** www.bcbst.com/providers/newsletters.shtml.

# Bluealert℠

of Tennessee

## Provider Service Lines†

Featuring "Touchtone" or "Voice Activated" Responses

**Note:** If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "Network Contracts or Credentialing" when prompted, to easily update your information.

**Commercial Lines** **1-800-924-7141**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**AccessTN/Cover Kids** **1-800-924-7141**
Monday-Friday, 8 a.m. to 6 p.m. (ET)

**BlueCare** **1-800-468-9736**

**TennCare*Select*** **1-800-276-1978**

**CHOICES** **1-888-747-8955**

**BlueCare Plus℠** **1-800-299-1407**

**BlueChoice℠** **1-866-781-3489**

**SelectCommunity** **1-800-292-8196**
Monday–Friday, 8 a.m. to 6 p.m. (ET)

**BlueCard**
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**BlueAdvantage** **1-800-841-7434**

**BlueAdvantage Group** **1-800-818-0962**
Monday–Friday, 8 a.m. to 5 p.m. (ET)

**eBusiness Technical Support**
Phone: Select Option 2 at **(423) 535-5717**
e-mail: eBusiness_service@bcbst.com
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)



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FEBRUARY 2015

# Bluealert℠

## BlueCross BlueShield of Tennessee, Inc.

(Articles apply to all lines of business unless stated otherwise)

CLINICAL

### Medical Policy updates/changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

**Effective March 23, 2015**

- Lymphedema Devices

**Note:** These effective dates also apply to BlueCare Tennessee pending State approval.

### NEW New drugs added to Commercial Specialty Pharmacy listing

The following medication will be added to our Specialty Pharmacy drug list. Medication(s) requiring prior authorization are identified by (PA).

**Provider-administered via the medical benefit:**

- Blincyto (PA)
- Blincyto (blinatumomab) is indicated for the treatment of Philadelphia chromosome negative relapsed or refractory B-cell precursor acute lymphoblastic leukemia.

BlueCross medical appropriateness criteria is as follows:

**Blinatumomab** is considered medically appropriate if all of the following criteria are met: Diagnosis of acute lymphoblastic leukemia (ALL) that is all of the following:

- Philadelphia chromosome-negative
- Drug must be initiated and administered in the hospital for a minimum of nine days
- B-cell precursor disease that is any **one** of the following:
  - Relapsed
  - Refractory

Providers may obtain prior authorization (PA) for the following:

- Provider-administered drugs that have a valid HCPCS code by logging onto BlueAccess℠, the secure area of www.bcbst.com. Select **Service Center** from the Main Menu, followed by **Authorization/Advance Determination Submission**. Physicians not registered with BlueAccess or needing assistance using our website should contact eBusiness Solutions†.
- Provider-administered specialty drugs that do not have a valid HCPCS code by calling 1-800-924-7141

**Note:** BlueCross BlueShield of Tennessee updates its web authorization forms on a quarterly basis. If the HCPCS code is not available, it will be in the near future.

## BlueCross BlueShield of Tennessee, Inc.

ADMINISTRATIVE

### Continue to speak to your patients about the flu

Remember to talk about anti-viral medications with your patients. Flu has officially reached epidemic levels in the U.S. and has the potential to be particularly lethal this year. According to the Centers for Disease Control & Prevention (CDC), flu-related deaths peak in years where the H3N2 strain of influenza A predominates. Walgreens, tracks prescriptions for antiviral drugs and reports the top flu areas for Tennessee are Chattanooga, Nashville, Knoxville, and the Tri-Cities. This year the CDC tested 127 strains of influenza A and B for sensitivity to oseltamivir and zanamivir. None were found to be resistant to antivirals. In addition to encouraging vaccination to your patients, be sure to inform them to seek antiviral medications as soon as symptoms appear.

### 2015 HEDIS® medical record review project to begin

Each year BlueCross BlueShield of Tennessee and BlueCare Tennessee are required to report Healthcare Effectiveness Data and Information Set (HEDIS®) measures to maintain National Committee for Quality Assurance (NCQA) accreditation. Data is collected for Medicaid, Medicare Advantage, Commercial and CoverKids products.

We are seeking medical records related to prevention and screening, diabetes care, cardiovascular conditions, access and availability, medication management and utilization measures and will be contacting you soon.

Your cooperation is greatly appreciated and important to the success of the outcome. We will work with you to arrange the most appropriate method for obtaining medical record information, which may include scheduling an onsite review in your office or arranging delivery of records. Oversight audits of our medical record abstraction methodology require that we scan pertinent elements of member charts. If you use a copy service, please ask them to respond promptly to record requests.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows Covered Entities (such as practitioners and their practices) to disclose protected health

information (PHI) to another Covered Entity (such as BlueCross and BlueCare Tennessee) without patient authorization as long as both parties have a relationship with the patient and the PHI pertains to that relationship for the purposes of treatment, payment, and health care operations. Additionally, all nurses reviewing charts on behalf of BlueCross and BlueCare Tennessee have signed a HIPAA-compliant confidentiality agreement.

## REMINDER: Maternity authorizations for Commercial members

Prior authorization is not required for an inpatient stay as long as the hospitalization results in the delivery of the newborn even when the member labors on day one and delivers on day two.

Complications of pregnancy will still require authorization if delivery is not expected during that hospital stay.

## Prior authorization requirement changes for musculoskeletal services

Effective immediately, prior authorization requirements for the following CPT® codes have been updated for Commercial and Medicare Advantage plans.

NEW New codes requiring prior authorization for spinal surgery: For Commercial: 0375T, 22858

NEW New codes requiring prior authorization for pain management: For Commercial and Medicare Advantage: 22510, 22511, 22512, 22513, 22514, 22515

Deleted codes no longer in use for Pain Management:
For Commercial and Medicare Advantage: 22520, 22521, 22522, 22523, 22524, 22525
Additional deleted codes for Medicare Advantage only: 72291, 72292

Before submitting a prior authorization request to the BlueCross Musculoskeletal Program (administered by Triad Healthcare), please verify member benefits and eligibility by contacting the BlueCross Provider Service Line† or through BlueAccess, the secure area on our website, www.bcbst.com.

Prior authorization requests can be submitted via fax or through BlueAccess. (When submitted online, the musculoskeletal code must be primary.)

## REMINDER: Be aware of member rights and responsibilities

As a BlueCross BlueShield of Tennessee network provider, you should know what our members are being told to expect from you and what you have the right to expect from those members. To comply with regulatory and accrediting requirements, we periodically remind members of their rights and responsibilities. These reminders are intended to make it easier for members to access quality medical care and to attain services.

Member rights and responsibilities are outlined in the BlueCross BlueShield of Tennessee and BlueCare Tennessee provider administration manuals, which are available online at www.bcbst.com and bluecare.bcbst.com/

## REMINDER: Dual-network health care plans now available in Middle Tennessee

Some BlueCross members in the Middle Tennessee area have dual-network health care plans that allow them to make a network choice each time they seek medical care. BlueCross has partnered with MissionPoint to offer members in Middle Tennessee the opportunity to seek care from providers that participate in both Network M and Network P.

Members with this plan will have access to MissionPoint's clinically-integrated support services at no charge to them. Providing these services should reduce repeat hospital and emergency room visits and better manage members' chronic conditions.

Member ID cards show both provider networks. Provider reimbursement for services to these members is based on the terms of the network that is listed **first** on the member ID card.

For additional information see the Frequently Asked Questions available online at www.bcbst.com/providers/Dual-Networks-Health-Care-Plan-FAQs.pdf.

## REMINDER: CAQH streamlines the credentialing process

BlueCross BlueShield of Tennessee has partnered with the Council for Affordable Quality Healthcare (CAQH®) to offer practitioners Universal Provider Datasource (UPD), a universal credentialing application tool. With a single, uniform online application, practitioners can enter their information free of charge to access, manage and revise that information at their convenience.

Beginning Jan. 1, 2015, BlueCross requires new credentialing applications from licensed health care professionals to be routed through CAQH. The UPD Quick Reference Guide, available on the CAQH website, www.caqh.org/pdf/UPDbrochure.pdf, provides step-by-step instructions for online registration and how to get started using UPD.

**Note:**

- Credentialing for participation in all BlueCross networks, except CHOICES, is available through the CAQH credentialing tool.
- Facilities are not eligible for credentialing through CAQH at this time.

## REMINDER: Electronic claim filing resources

As of Jan. 1, 2015, we began executing the electronic claims filing requirement pursuant to the BlueCross Minimum Practitioner Network Participation Criteria. To review the letter mailed to providers in December, please go to: www.bcbst.com/providers/ecomm/Electronic-Claims-Provider-Notice-1211.pdf. BlueCross has several resources available to assist providers in making the transition to a fully electronic submission environment:

**Corrected/Secondary Claims** – BlueCross accepts corrected and secondary claims electronically for institutional, professional, and dental claim types. Please share our technical guides with your vendor in order to ensure your system can file these claims electronically

- Corrected Claims: www.bcbst.com/providers/ecomm/bcbst_5010/5010_Corrected_Claims.pdf
- Secondary Claims: www.bcbst.com/providers/ecomm/bcbst_5010/Electronic_Secondary_Claim_Guideline.pdf

**eBusiness User Guide** – Information on processes and reports used when filing Electronic Data Exchange (EDI) claims can be found here:

- eBusiness User Guide: www.bcbst.com/providers/ecomm/eBusiness%20User%20Companion%20Guide_04232013.pdf

NEW **Supplemental EDI Information** – A technical guide has been created to assist providers that must file additional details on certain types of services that require invoice data, drug data, or any sort of additional documentation. Also covered in this guide is the new PWK process for submitting attachments for electronic claims:

- Supplemental EDI Information: www.bcbst.com/docs/providers/Supplemental-EDI-Information.pdf

- PWK Fax Coversheet: www.bcbst.com/docs/providers/PWK-Coversheet.pdf

Our eBusiness team can answer questions you may have about electronic claims filing, BlueAccess, or any other topic related to our electronic offerings. Contact us at (423) 535-5717, option 2, for assistance.

# Federal Employee Program (FEP)

**ADMINISTRATIVE**

## REMINDER: Federal Employee Program requests

Federal Employee Program (FEP) Advance Benefit determination and predetermination requests should be faxed to (423) 591-9091 for review.

Submit all inpatient hospital and hospice authorization requests, including wound vac requests for members who are in an inpatient facility through Commercial utilization management via BlueAccess or by faxing the request to 1-866-558-0789. Prior authorization for home health or skilled nursing facility care is not currently required by FEP.

# BlueCare Tennessee

**ADMINISTRATIVE**

## Member access and availability standards

Compliance with wait times is important to ensure our members receive care in the appropriate setting and at the appropriate time. Short wait times encourage members to seek care with their regular provider, rather than using the emergency room inappropriately.

Ease of access to a regular provider is a foundation of the primary care medical home, helps members stay current with preventive care screenings, and encourages members to seek care before complications occur.

BlueCare Tennessee has defined specific standards for routine and urgent care, including physical and behavioral health. These standards are monitored via a member survey on office wait time experience.

For additional information on Access and Availability Standards, please refer to the *BlueCare Tennessee Provider Administration Manual* available online at http://bluecare.bcbst.com/forms/Provider%20Information/BCT_PAM.pdf.

## REMINDER: Allowable incontinent supplies

The Budget Reduction Requirements from the Bureau of TennCare, effective July 1, 2014, require that any more than 200 incontinent supplies per member per month is Medically Necessary. BlueCare Tennessee will perform a retro review on claims that exceed the allowable monthly supply. The review will require the physician order and clinical records supporting the incontinent supply request.

## Tennessee Health Care Innovation Initiative

The Tennessee Health Care Innovation Initiative February reports will be based on the provider's Contract Entity rather than the provider's Tax Identification Number. The Contract Entity is an internal code set up in the BlueCross claims adjudication system tying a provider to that code based upon their executed contracts.

The reporting periods for the year 2015 for BlueCare, TennCare*Select* and CoverKids lines of business will be used for incentives and/or financial payouts in 2016. Reports for Commercial lines of business will be available however; they are for informational purposes only.

See the BlueCare Tennessee website at: bluecare.bcbst.com/Providers/Provider-Education-and-Resources/THCII.html for more information related to the Tennessee Health Care Innovation Initiative. Additional information is also available on the State of Tennessee website at www.tn.gov/HCFA/strategic.shtml.

## BlueAccess enhancements for behavioral health providers

As of Jan. 1, 2015, BlueCare Tennessee behavioral health providers can submit authorization requests through BlueAccess, the only portal needed by behavioral health providers participating in the BlueCare, TennCare*Select*, and BlueCare Plus (HMO SNP)℠ networks. We are excited about the functionality of this online tool and encourage providers to use it for all future authorization requests. Contact your eBusiness marketing representative for training materials.

## REMINDER: Are you seeing your assigned members?

We all know how important it is for Primary Care Providers (PCPs) to help coordinate our members' health care needs. As a BlueCare Tennessee PCP, it is your responsibility to verify any BlueCare/TennCare*Select* member you see is assigned to your patient listing or to another participating PCP in your group.

We are proud to offer access to the ***NEW*** BlueCross PCP Member Roster. The data in this application is updated weekly and is available to providers through BlueAccess, our secure provider portal. The PCP Member Roster application has new functionality including the ability to search for providers tied to a group, as well as export and print capabilities.

## Appointment of select incontinence suppliers

BlueCare Tennessee is preparing to award selected providers as the suppliers of incontinence products to BlueCare Tennessee members. Due to the implementation of the new TennCare Contract in Middle Tennessee, effective Jan. 1, 2015, there has been a significant membership shift and change. We have elected to delay this award until May 15, 2015, to allow for the membership to stabilize. Current suppliers should continue to provide existing members with incontinence supplies until otherwise notified.

## New Abortion, Sterilization and Hysterectomy forms available*

The Bureau of TennCare has published new Abortion, Sterilization and Hysterectomy (ASH) forms with instructions. Note the following changes:

- The member's Social Security Number (SSN) was removed and replaced with the date of birth. The physician's SSN was also removed and replaced with their NPI on the abortion form.
- The member's Medicaid ID number was removed and replaced with the date of birth on the hysterectomy form. The form has also been revised for clarity to ensure providers only complete one section of the form.
- The "physical street address" was added to the instructions for item 14. This information must include the city, state, and zip code.

These forms, along with their instructions, can be accessed online in the ASH section of the *BlueCare Tennessee Provider Administration Manual* at bluecare.bcbst.com/forms/Provider%20Information/BCT_PAM.pdf.

## Community resources

Factors that have the most impact on a patient's health are often outside the traditional clinical health care system. These factors include everyday hurdles such as housing,

transportation, health literacy, and social supports. Community Resource Agencies are available to assist members in overcoming these hurdles which improves their access to care, and thereby improves quality.

BlueCare Tennessee has updated the Community Resources page on the BlueCare Tennessee website to include additional resources to assist our members. These links have been organized by health care topic and include a description of the services provided by each. The Community Resource link can be located at bluecare.bcbst.com/Members/Member-Assistance/Community-Resources.html

Please consider using these resources as you continue to provide excellent care to our members and your patients.

QUALITYCARE REWARDS

## REMINDER: Final quality scores for Medicare Advantage pay for performance program coming

Final quality scores for the Medicare Advantage pay for performance program are coming in late February or early March, 2015. These scores are used to determine physicians fee schedules for 2015 and are an important step in ensuring quality care for our members and your patients. Claims and medical records for services rendered in 2014 may be submitted to BlueCross by January 31. Further instructions for how to submit can be found on the Quality Care Rewards website (bcbst.com/docs/providers/quality-initiatives/Data-Submission-Resource-Guide.pdf).

*These changes will be included in the appropriate 1Q or 2Q 2015 provider administration manual update. Until then, please use this communication to update your provider administration manual.

**Archived editions of BlueAlert are available online at** www.bcbst.com/providers/newsletters.shtml.

## Notes

# Bluealert℠

of Tennessee

## Provider Service Lines†

Featuring "Touchtone" or "Voice Activated" Responses

**Note:** If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

**Commercial Lines** **1-800-924-7141**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**AccessTN/Cover Kids** **1-800-924-7141**
Monday-Friday, 8 a.m. to 6 p.m. (ET)

**BlueCare** **1-800-468-9736**

**TennCare*Select*** **1-800-276-1978**

**CHOICES** **1-888-747-8955**

**BlueCare Plus℠** **1-800-299-1407**

**BlueChoice℠** **1-866-781-3489**

**SelectCommunity** **1-800-292-8196**
Monday–Friday, 8 a.m. to 6 p.m. (ET)

**BlueCard**
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
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**BlueAdvantage** **1-800-841-7434**

**BlueAdvantage Group** **1-800-818-0962**
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Phone: Select Option 2 at **(423) 535-5717**
e-mail: eBusiness_service@bcbst.com
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
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BLUESHIELD
OF TENNESSEE, INC.

MARCH 2015

# BlueAlert℠

## BlueCross BlueShield of Tennessee, Inc.

(Articles apply to all lines of business unless stated otherwise)

**CLINICAL**

### Medical Policy updates/changes

The *BlueCross BlueShield of Tennessee Medical Policy Manual* has been updated to reflect the following policies. The full text of the policies listed below can be accessed at www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

**Effective April, 2, 2015**

- Proteomic Testing for Targeted Therapy in Non-Small Cell Lung Cancer
- Patient-Specific Cutting Guides and Custom Knee Implants
- Serum Biomarker Testing for Lupus

**Note:** These effective dates also apply to BlueCare/TennCare*Select* pending State approval.

**ADMINISTRATIVE**

### Behavioral Health Network being built

Effective Jan. 1, 2016, BlueCross will assume responsibility for behavioral health contracting and credentialing for its Commercial and Medicare Advantage lines of business.

Additional information will be sent directly to behavioral health providers. In the meantime, professionals can begin preparing for the transition by visiting the website for the Council for Affordable Quality Healthcare, Inc. (CAQH) to ensure credentialing and profile information is complete and current. Providers may contact their local Behavioral Health Provider Network Manager with any questions

### Filing corrected bills*

Electronic submission is the preferred method for filing corrected bills. Corrected bills are claims that have been **processed** (providers receive a remittance advice that includes the claim) and paid incorrectly because of an error or omission on the claim.

Although electronic submission is the preferred method, sometimes it's necessary to file paper corrected claims. The guidelines currently tell providers to bill either qualifier 7 (replacement of a prior claim) or 8 (void/cancel of a prior claim) in block 22 of a CMS 1500 claim form. However it is also important to include the original claim number in block 22 in the section (ORIGINAL REF. NO) next to the qualifier. This space is intended for the original processed claim number found on your remittance advice. Failure to include the proper indicator and original claim number may result in a claim denial.

### Commercial appeals*

To help ensure appeals are handled in the most timely manner, it is important to submit to the correct location according to **type** of appeal request indicated below.

- Appeals related to a **claim** should be sent to:

  **BlueCross BlueShield of Tennessee**
  **1 Cameron Hill Circle, Suite 0039**
  **Chattanooga, TN 37402-0039**

- Commercial appeals related to an **authorization** with a **medical necessity** adverse determination should be accompanied by a copy of the denial letter OR a copy of the appeals form located at: www.bcbst.com/providers/forms/Commercial-Utilization-Management-Appeal.pdf.

  Requests can be faxed to (423) 591-9451 or mailed to:

  **BlueCross BlueShield of Tennessee**
  **1 Cameron Hill Circle, Suite 0017**
  **Chattanooga, TN 37402-0017**

### Vaccine hesitant parents

Parents often rely on pediatricians to help them navigate a confusing sea of child health information. Immunizations and vaccines are just one area of concern for families. Making time to talk with parents about vaccines during the well-child visit may be challenging. The Centers for Disease Control and Prevention (CDC), American Academy of Pediatrics (AAP), and American Academy of Family Physicians (AAFP) have created materials to help with assessing parents' needs, identifying the role they want to play in making decisions for their child's health, and then communicating in ways that meet their needs. These resources are collectively called *Provider Resources for Vaccine Conversations with Parents*. See the resources available: www.cdc.gov/vaccines/hcp/patient-ed/conversations/index.html.

For conversations with parents who are hesitant about having their child vaccinated, AAP also offers videos which explain risk communication theory and model conversations. They can be viewed individually or as part of a larger group for discussion. The videos are available here: www2.aap.org/immunization/pediatricians/communicating.html.

### Medical record requests

You may occasionally receive requests for records which may be used for a variety of reasons including audits and medical necessity reviews. These requests must be handled as a priority and all requested information must be submitted. Failure to do so may result in payment being denied or recovered.

Remember, as a BlueCross network provider you are contractually obligated to submit medical records for our members at no charge.

## Electronic claim filing

As a reminder, on Jan. 1, 2015, BlueCross began executing the electronic claims filing requirement as outlined to the BlueCross Minimum Practitioner Network Participation Criteria. All claims should now be filed electronically. To review the letter mailed to providers in December 2014, please go to: www.bcbst.com/providers/ecomm/Electronic-Claims-Provider-Notice-1211.pdf
Our eBusiness team is available to assist providers in making the transition to a fully electronic submission environment. No claims will be denied or returned on the sole basis of being a paper claim; if you receive returns or rejections and have questions, please contact eBusiness Technical Support for assistance†.

## Tips for calling the Provider Service Line (1-800-924-7141)

*(Our phone options recently changed)*

When calling our Provider Service line, choose from the following options for information regarding BlueCross members covered by our Commercial lines of business:

- Option 1 – Automated eligibility information
- Option 2 – To verify benefits prior to services
- Option 3 – Automated claims status information
- Option 4 – To discuss questions regarding a specific claim

By selecting the correct option that fits your reason for calling, it will help reduce wait times and ensure calls are routed to the right agent the first time.

## Guidance on 2015 drug testing code changes

The Centers for Medicare & Medicaid Services (CMS) released guidance in October 2014 for clinical laboratory fee schedules that proposed a delay for pricing the new 2015 CPT® codes for drugs of abuse tests until further information and education is obtained. Instead, providers are advised to use alphanumeric "G" codes to replace the 2014 CPT® codes that are being deleted for 2015.

BlueCross BlueShield of Tennessee and BlueCare Tennessee are adopting the CMS recommendation to use 2015 G-codes for all drug testing – both screening and confirmatory tests – for all lines of business. The G-codes help address overutilization of drug testing, offer established rates and ensure a more efficient and streamlined claims payment process.

Starting April 1, 2015, BlueCross and BlueCare Tennessee payment systems will automatically deny claims using 2015 CPT® codes for drug screenings and confirmatory tests.

For more information and a list of the 2015 G-codes, please refer to the CMS documentation "Clinical Laboratory Fee Schedule (CLFS)" located at:

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2015-CLFS-Codes-Final-Determinations.pdf

## Appropriate billing for newborn hearing test

The technical component for newborn hearing tests (as well as other diagnostic studies) that are performed on patients in an inpatient setting should not be billed by a professional provider. The Diagnosis Related Group (DRG) payment methodology reimburses the facility where the patient is an inpatient for the technical portion of all diagnostic testing and should not be reported by the physician interpreting the results. Physicians should report **only** the professional component for procedures in the inpatient setting. As a reminder, CPT® code 92586 is a technical component code per the Medicare Physician Fee Schedule, therefore, should not be reported by a physician when the patient is in an inpatient setting.

## Claim denials due to incorrect submission

In January 2014 BlueCross implemented the CMS1500 Claim Form (02/12 Version). Due to changes to several boxes on this new version of the claim form we have experienced a high volume of rejections. Please see the information at the following link www.bcbst.com/providers/news/ for more information. Details for completing all boxes on the CMS1500 form can be found in the NUCC CMS1500 Claim Form Manual available at nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2012_02-v2.pdf. These requirements align with the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3 (5010) and 005010X222A1 Technical Report Type 3 (5010A1).

## REMINDER: Refer members to in-network providers

Our members get the most from their health benefits when they visit participating network providers. As one of our network providers, please remember you are contractually obligated to refer our members to other contracted network providers. This is especially important when referring members to hospitals, or for lab, DME and any other ancillary services. Our "Find a Doctor" tool on bcbst.com can be used to easily locate other participating network providers.

## REMINDER: CAQH streamlines the credentialing process

BlueCross BlueShield of Tennessee has partnered with the Council for Affordable Quality Healthcare (CAQH®) to offer practitioners ProView™ formerly Universal Provider Datasource (UPD), a universal credentialing application tool. With a single, uniform online application, practitioners can enter their information free of charge to access, manage and revise that information at their convenience.

As of Jan. 1, 2015, BlueCross requires new credentialing applications from licensed health care professionals to be submitted through CAQH. The CAQH website, http://proview.caqh.org/, provides step-by-step instructions for online registration and how to get started using ProView.

**Note:**

- Credentialing for participation in all BlueCross networks, except CHOICES, is available through the CAQH credentialing tool.
- Facilities are not eligible for credentialing through CAQH at this time.

## REMINDER: Recovery of overpayments

BlueCross will issue notification when an overpayment is identified. The overpayment to physicians and ancillary providers will be recovered through an offset to their remittance advice, 45 days from the date of the overpayment notification letter. The 45 days is granted to allow providers time to review their records and determine whether they agree with BlueCross' overpayment determination. Providers who feel the audit decision is incorrect should follow the Provider Dispute Resolution Process (PDRP) by submitting their request within 30 days from the date of the notification letter. Information related to

the PDRP is available online in the provider administration manuals at www.bcbst.com.

Providers, including facilities, should not send reimbursement by check to BlueCross.

**Note:** The Federal Employee Program (FEP) requires BlueCross to continue notifications up to 120 days from the date of the initial overpayment notification letter until the payment is recovered.

# BlueCare Tennessee

**ADMINISTRATIVE**

## REMINDER: Are you seeing your assigned members?

We all know how important it is for Primary Care Providers (PCPs) to help coordinate our members' health care needs. As a BlueCare Tennessee PCP, it is your responsibility to verify any BlueCare/TennCare*Select* member you see is assigned to your patient listing or to another participating PCP in your group.

We are proud to offer you access to the ***NEW*** BlueCross *PCP Member Roster* application which is accessible to providers through BlueAccess℠, our secure provider portal. The PCP Member Roster application has new functionality including the ability to search for providers tied to a group, as well as export and print capabilities. The data is updated weekly.

When you provide health care to a BlueCare Tennessee member that is not on your PCP *Member Roster* you will see code WW3 on your remittance advice. Beginning Aug. 1, 2015, reimbursement for service will be denied if you treat a BlueCare Tennessee member that is not assigned:

1. to you,
2. a physician in your office, or
3. your on-call physician.

## NEW Behavioral health transition of care team

BlueCare Tennessee has created a Transition of Care Team (TOC) to facilitate care coordination between facilities and other health care providers to improve care for our members and reduce avoidable hospital readmissions.

Our goal is to:

- Identify members' health care barriers, such as environment and non-compliance with medications.
- Transition the member into a population health program.
- Work with the facility discharge planner to verify the discharge plan is understood by the member so they can better adhere to the treatment plan.

## Controlling high blood pressure

BlueCare Tennessee is committed to providing health care providers with important information that supports controlling high blood pressure. Our members received information in February about controlling high blood pressure and continuing on antihypertensive medications (ACE and ARBs) if prescribed. Please help reinforce these messages by talking with our members about controlling high blood pressure and the impact dietary or lifestyle changes can make for them. Members diagnosed with high blood pressure may not realize the importance of watching their sodium intake or be aware of the importance of medication adherence.

Some providers may receive an on-site visit from our Provider Relations Consultants to share an educational packet that you might find useful in treating your BlueCare and TennCareSelect patients diagnosed with high blood pressure. Members may be more likely to respond to suggestions from their health care provider, so your help with these awareness efforts is appreciated. Educational information for you to print and share with your members is available online at bluecare.bcbst.com/Health-Programs/Population-Health/Heart-Health.html.

# Medicare Advantage

(These articles apply to BlueAdvantage (PPO)℠, BlueChoice (HMO)℠ and BlueCare Plus (HMO SNP)℠ unless otherwise stated.)

**ADMINISTRATIVE**

## Medicare & Medicaid Services Prescription Information

*(Provider Information Based on SE1434)*

The Centers for Medicare & Medicaid Services (CMS) finalized CMS-4159-F "*Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*" on May 23, 2014. This rule requires physicians and, when applicable, other eligible professionals including dental providers who write prescriptions for Part D drugs to be enrolled in an approved status or have a valid opt-out affidavit on file for their prescriptions to be covered under Part D.

BlueAdvantage and BlueCare Plus prescribers of Part D drugs must submit their Medicare enrollment applications or opt-out affidavits to their Part B Medicare Administrative Contractors (MACs) by June 1, 2015, or earlier, to ensure that MACs have sufficient time to process the applications or opt out affidavits and avoid their patients' prescription drug claims from being denied by their Part D plans, beginning Dec. 1, 2015.

For additional information please go to: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html.

## Skilled Nursing Facilities HIPPS Codes

Skilled Nursing Facilities (SNFs) should submit a HIPPS code from the admission assessment completed during the covered SNF stay, only if an assessment was **not** completed for BlueAdvantage members.

**Stays more than 14 days –** If the admission assessment was completed prior to the covered portion of the stay, submit a HIPPS code from:

- another assessment completed during the covered portion of the stay;
- the most recent assessment completed prior to the covered portion of the stay; or
- a code from the most recent assessment if no assessment was completed.

**Stays of 14 days or less –** and no admission assessment was completed before discharge for a stay, submit a code:

- from another assessment from the stay; or
- use default code 'AAA00'.

**Submit a default code only if:**

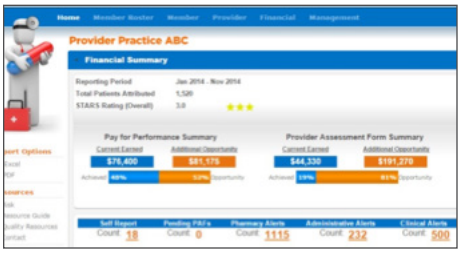
- the beneficiary was discharged prior to the completion of the initial assessment; or
- no other assessment was completed during the stay.

Refer to the Dec. 4, 2014, Centers for Medicare & Medicaid Services memo at www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/encounterdatahippsmemo.pdf

## Stars ratings now available; Provider reimbursement rates changing April 1

The Medicare Advantage Quality Incentive Program offered providers enhanced reimbursement for closing defined gaps in care through Dec. 31, 2014. Providers may now visit BlueAccessSM to view their current Stars rating based on the clinical data received from their practice. After logging in to BlueAccess through www.bcbst.com/providers and accessing the Quality Rewards tool, this home screen will appear with the provider's Stars rating.

Providers can click on the "Financial" tab on the main menu to see their new fee schedules.




Star ratings, as calculated by the previous year's performance, will impact provider's current reimbursement rates, effective April 1, 2015. Providers should refer to their contract amendments for information about their base rate, the quality escalator and total earning potential.

## Patient Assessment Form incentive changing in 2015

BlueCross is again offering an incentive to physicians who complete and submit a Patient Assessment From for BlueAdvantage and BlueChoice members. The incentive will work a little differently in 2015 when physicians will have the opportunity to earn the highest bonus by completing and submitting the forms during the first quarter. See the incentive schedule below to see what bonus your practice can receive.

- $250 for dates of service between January 1 and March 31, 2015
- $200 for dates of service between April 1 and June 30, 2015
- $175 for dates of service between July 1 and September 31, 2015
- $150 for dates of service between October 1 and December 31, 2015

For additional information about the Patient Assessment Form please visit our website: http://www.bcbst.com/providers/quality-initiatives.page?

## Peer-to-peer option added to call-in prompts

Effective immediately when calling the BlueCross BlueShield of Tennessee Provider Service line† concerning a BlueAdvantage/ BlueChoice claim denial, you have the option of setting up a peer-to-peer conversation with a medical director using the menu of choices at the beginning of the call. Simply say "Peer" when prompted and you will be transferred to a staff member who will schedule the call.

## Incentives available for Blue Advantage and BlueChoice members in 2015

In 2015 Blue Advantage Members can earn rewards on up to six free screenings that can be provided in your office or through convenient in-home screenings for members who find it hard to travel outside the home. A $15 gift card is available for each of the screenings listed below:

- Mammogram (Women only.)
- Colorectal Cancer Screening (Men and women. In-home test kit available.)
- Bone Mass Measurement (Women only. In-home screening available.)
- Diabetes Retinal Eye Exam (Diabetic members. In-home screening available. See article about Diabetic Retinal Exam for explanation of incentive amounts.)
- HbA1c (Diabetic members. In-home test kit available.)
- Kidney Function Screening (Diabetic members. In-home test kit available.)

## Patient incentive available for diabetic retinal exams in 2015

For diabetic patients, a retinal exam is critically important to protecting against vision loss. Unfortunately, many diabetic patients neglect to have this simple procedure. Encourage your patients to schedule one today to ensure a lifetime of good eyesight and remind them they'll get rewards when they do.

If a BlueAdvantage or BlueChoice member receives the exam from an optometrist or ophthalmologist, they will receive a $40 gift card. If they receive the eye exam with our in-home service, they will receive a $15 gift card.

Additional information can be found online at www.bcbst-medicare.com/2015/health-and-wellness/my-healthpath/index.page?nav=header

QUALITYCARE REWARDS

(Articles apply to all lines of business unless stated otherwise)

## HEDIS® Focus: March is National Colon Cancer Awareness Month

HEDIS® quality standards are designed to offer a consistent way of measuring the quality of care provided to members of a health plan. This measure focuses on patients age 50 to 75 years of age who have received colorectal cancer screening. There are three acceptable types of screening; fecal occult blood testing (annually), flexible sigmoidoscopy (every five years) and colonoscopy (every 10 years).

Ways to improve compliance with this measure:

- Discuss the importance of colorectal cancer screening and identify the screening method that best suits your patient's needs.
- There are two types of fecal occult blood testing: guaiac (gFOBT) and immunochemical (iFOBT). If guaiac testing is used, three samples must be submitted. If immunochemical testing is used, **only one sample is required**. If the type of testing is not documented, it will be assumed that guaiac testing was done (requiring three samples).
- Results are not required if documentation is clearly part of medical history. If not, documentation of results will be required. *(This is to ensure the test was completed and not simply ordered).*
- A digital rectal exam is not counted as evidence of colorectal screening

*These changes will be included in the appropriate 1Q 2015 provider administration manual update. Until then, please use this communication to update your provider administration manual.

**Archived editions of BlueAlert are available online at**

www.bcbst.com/providers/newsletters.shtml.

## Notes

# Bluealert℠

of Tennessee

## Provider Service Lines†

Featuring "Touchtone" or "Voice Activated" Responses

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of Tennessee
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bcbst.com

APRIL 2015

# BlueAlert℠

## BlueCross BlueShield of Tennessee, Inc.

(Articles apply to all lines of business unless stated otherwise)

**CLINICAL**

### NEW Drugs added to commercial Specialty Pharmacy listing

Effective April 1, 2015, the following drugs have been added to our Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

**Provider-administered via medical benefit:**

- Blincyto (PA)
- Keytruda (PA)
- Lemtrada (PA)
- Opdivo (PA)

**Self-administered via pharmacy benefit:**

- Duopa (PA)
- Evotaz
- Ibrance (PA)
- Lenvima (PA)
- Lynparza (PA)
- Prezcobix
- Vitekta

Providers can obtain prior authorization for:

- **Provider-administered drugs** that have a valid HCPCS code by logging onto BlueAccess℠, the secure area of www.bcbst.com, selecting Service Center from the Main menu, followed by Authorization/Advance Determination Submission. If you are not registered with BlueAccess or need assistance, call eBusiness Technical Support†.
- **Provider-administered specialty drugs** that do not have a valid HCPCS code by calling 1-800-924-7141
- **Self-administered specialty drugs** by calling Express Scripts at 1-877-916-2271.

**Note:** BlueCross updates web authorization forms on a quarterly basis. If the HCPCS code is not available now, it may be in the near future.

### Diabetes screening for members with schizophrenia or bipolar disorder who are using antipsychotic medications

Individuals with schizophrenia or bipolar disorders are at high risk to develop diabetes among other serious health conditions. The risk for diabetes is even greater if those patients are prescribed antipsychotic medication which can cause weight gain and changes in metabolism. Screening patients with these conditions who are also taking antipsychotic medications may lead to earlier identification and treatment of diabetes.

BlueCare/TennCare*Select*, CoverKids and BlueCare Plus (HMO SNP)℠ are alerting Community Mental Health Centers and other community-based behavioral providers about the importance of screening for impacted members and encouraging them to share relevant clinical and medication information with Primary Care Providers. Members who require the screening should have one of the following tests completed:

- **Glucose test** (CPT® 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951)
- **HbA1c test** (CPT® 83036, 83037 CPT® II 3044-3046-F).

Thank you for your assistance in helping our members with serious behavioral health conditions to achieve and maintain improved health status.

## BlueCross BlueShield of Tennessee, Inc.

(Articles apply to all lines of business unless stated otherwise)

**ADMINISTRATIVE**

### Look for changes to *BlueAlert* coming soon

In an effort to simplify your daily interactions with BlueCross, we are excited to introduce a new and innovative way to view the latest publication of the BlueAlert provider newsletter on our company websites, www.bcbst.com and www.bluecare.com, The enhanced newsletter will provide an easy-to-navigate electronic format allowing quick access to more information by simply clicking links and hyperlinks referenced in the articles.

Additionally, you will soon be notified via postcard when the new BlueAlert format is available online. Each month, the postcard will highlight important articles that are included in the newsletter and how to access them.

We look forward to providing you with this new upgrade as we move forward in a more efficient, electronic environment.

Let us know what you think by completing the provider survey at www.surveymonkey.com/s/G7H2WSL. We value your feedback.

### Financial planning tool available for review

BlueCross believes in equipping our members with information that helps them make better, more-informed decisions about their health. This includes cost and quality information about providers in our commercial networks.

Updated cost and quality information is now available for your review. You can log into BlueAccess, our secure web portal, to view your data.

1. *You have a 60-day period to review this data before it is published.*
2. *You have the ability, within this 60-day window, to contest any data you believe to be inaccurate before it is published for members to view.*
3. *We have been publishing physician quality information since 2008; procedure costs have been made available since 2013.*

On June 1, 2015, our members will have access to this financial planning tool which also includes single procedure costs. The new financial planning tool will apply the member's cost-sharing, offering the member a more accurate estimation of his/her cost obligation. Provider cost and quality data is not affected by overlaying this member cost estimator.

Questions can be directed to NCCTquestions@bcbst.com.

## Aspire services available for members facing serious illness

BlueCross is pleased to announce a new partnership with Aspire Health beginning March 1, 2015, to provide an extra layer of home-based support to our Commercial members in Networks P and S and BlueAdvantage members (in Hamilton, Shelby and Davidson counties in Tennessee and contiguous counties) facing an advanced illness.

Aspire's team of physicians, nurse practitioners, social workers and chaplains are on call 24 hours-per-day, 7 days-per-week and primarily see patients in their homes to help with symptom management and advanced care planning, thereby preventing unnecessary emergency room visits and hospitalizations. BlueCross members enrolled in Aspire keep their primary care physician and other specialists. Aspire's intervention has been shown to have high patient and family satisfaction, improved quality of life for patients facing an advanced illness, and reduced hospitalizations by over 50 percent. Aspire services are currently available in Chattanooga, Memphis and Nashville. To refer a patient, please call (844) 232-0500 or visit www.aspirehealthcare.com to learn more.

## Health information privacy*

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, BlueCross BlueShield of Tennessee makes every effort to protect its members' individually identifiable health information.

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to 1) health plans, 2) health care clearinghouses, and 3) those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives rights to patients over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

Members and patients have the right to access their health information and to know how it is being protected. As such, **BlueCross requests providers maintain a notice of privacy practices and encourages them to publish such notices prominently on their websites.**

## REMINDER: Network enrollment for new providers

Health care providers practicing in Tennessee and bordering Tennessee counties who would like to participate in BlueCross BlueShield of Tennessee networks should complete the Provider Enrollment Form available on the company website at www.bcbst.com/providers/contracting-credentialing.page.

BlueCross has partnered with the Council for Affordable Quality Healthcare (CAQH®) to offer practitioners CAQH ProView™, a universal credentialing application tool. With a single, uniform, online application, practitioners can enter their credentialing information and later access, manage and revise that information at their convenience. The Universal Provider Datasource (UPD) credentialing application tool is available at no cost to practitioners and is located at proview.caqh.org.

## COMING SOON: Behaviorally Effective Healthcare in Pediatrics online training

In the next month the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) will be launching an online training program for Behaviorally Effective Healthcare in Pediatrics (BEHIP). There is no cost for the eight online training modules. The modules will provide pediatric health care providers with tools and strategies to screen, evaluate and manage patients with common behavioral health concerns. The modules range from 30 minutes to 1 hour to complete and cover the following topics:

- Introduction to Behavioral Health in Pediatrics
- Postpartum Depression
- Disruptive Behavior and Aggression
- Inattention
- Anxiety
- Depression
- Substance Abuse
- Coding & Workflow for Behavioral Health

Continuing Medical Education (CME) credit will be available for this training. For more information, contact the TNAAP Training Coordinator, Rebecca Robinson at rebecca.robinson@tnaap.org.

*This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of Vanderbilt University School of Medicine and the Tennessee Chapter of the American Academy of Pediatrics. Vanderbilt University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.*

## REMINDER: Request a peer-to-peer consultation when you call

Often providers call and would like to request a peer-to-peer consultation with a physician regarding one of our Commercial or Medicare Advantage members. To request this conversation, when you call us at 1-800-924-7141, you can simply say or choose the word "peer" from the options available in our HealthCare Management menu.

# BlueCare Tennessee

This information applies to BlueCare and TennCare*Select* plans, excluding dual-eligible BlueCare Plus (HMO SNP)SM unless otherwise stated

**ADMINISTRATIVE**

## Speech therapy clarification

BlueCare Tennessee established a process to facilitate the coordination of TENNderCare services when members under 21 years of age have been identified as needing to receive

therapy services in an educational setting. BlueCare Tennessee requires a copy of the child's Individualized Education Program (IEP) and a signed Release of Information/Parental Consent. This process is in support of the TENNderCare Connections process for IEPs.

Speech therapy is covered as medically necessary in accordance with TENNderCare requirements and must be performed by a licensed speech therapist. BlueCare Tennessee will NOT pay for speech therapy provided in a group setting in a school unless the group setting is specifically written in the IEP, specifically ordered by the Primary Care Provider and performed by a licensed speech therapist.

### REMINDER: Are you seeing your assigned members?

We are proud to offer you access to the ***NEW*** BlueCross BlueShield of Tennessee Primary Care Provider (PCP) Member Roster application. It is accessible to providers through BlueAccess, our secure provider portal. The PCP Member Roster application has new functionality including searching for providers tied to a group, export and print capabilities. The data is updated weekly. Generally, the turnaround time for PCP changes is within five (5) days; however, due to Statewide Implementation, we are experiencing a higher than normal volume. If a request has been submitted, please do not re-submit another one. Your patience is appreciated.

**If the member ID card does not show the correct PCP assignment**, a new feature is available to members offering them the ability to print a temporary ID card to use while they are waiting on a copy of their permanent member ID card. Before denying the patient access to your services, please verify eligibility on BlueAccess and remind them of the temporary ID card feature.

We all know how important it is for PCPs to help coordinate our members' health care needs. As a BlueCare Tennessee PCP, it is your responsibility to verify any BlueCare/TennCare*Select* member you see is assigned to your patient listing or to another participating PCP in your group *prior to treatment*.

When you treat a member that is not on your PCP Member Roster you will see code WW3 on your remit. Beginning Aug. 1, 2015, this service will be denied when you treat a member that is not assigned to you, a physician in your office or your on-call physician.

### REMINDER: Billing requirements for behavioral health providers

Mental health outpatient facilities are required to include the rendering provider on all professional claims when the provider rendering the service to BlueCare Tennessee, BlueCare Plus℠ or CoverKids members is different than the billing provider. In the case of an agency billing for services not provided by a licensed clinician, the medical director or other supervising professional may be entered on the claim as the rendering provider.

Failure to provide this information could result in a denial or reduction in reimbursement.

### REMINDER: Complete the TENNderCare checkup when performing sports physicals

Many children play sports, which is also a good opportunity to provide the TENNderCare checkup. To be considered a TENNderCare checkup, the following should be performed at the visit:

- Health history
- Complete physical exam
- Lab tests as needed
- Shots as needed
- Vision/hearing screening
- Developmental/behavioral screening as appropriate
- Advice on how to keep healthy

For more information about TENNderCare checkups and billing, please refer to http://www.tnaap.org/.

## Medicare Advantage

This information applies to BlueAdvantage℠ HMO/PPO plans, excluding dual-eligible BlueCare Plus℠ unless stated otherwise.

**ADMINISTRATIVE**

### Acute inpatient concurrent review updates and coverage extension requests

Medicare Advantage currently reviews all inpatient services for medical necessity against the Centers for Medicare & Medicaid Services (CMS) and MCG, formerly Milliman Care Guidelines criteria. Initial inpatient authorizations are for seven (7) days regardless of diagnosis with a clinical update due on day eight (8) for any extension approvals. All days after day eight (8) are reviewed for ongoing medical necessity and individual days may not be approved for coverage if the intensity of service is not met or for delay in clinical services. At no time will the DRG payment be reduced, but this may impact any outlier payments.

Clinical updates need to include information supporting the need for continued acute inpatient services such as:

- Physician progress notes
- Physician orders
- Rehab service notes
- Discharge planning

### Medicare Advantage providers earn high marks on quality

In 2014, BlueCross launched an effort to improve the care our members receive by working with health care professionals to close important gaps in care and gather all relevant medical records to achieve the highest possible quality ratings. The effort was a success, as 197 individual Medicare Advantage providers and 11 provider groups improved their Star quality ratings and will see increased reimbursement rates effective April 1, 2015.

In addition, another 3,293 providers maintained the same Star ratings, meaning they once again achieved quality scores ratings that continue their current level of reimbursement for another year.

BlueCross deployed teams with specific expertise in clinical quality, helping providers better understand how to interpret their current scores and offering proven tactics to help providers improve scores going forward. Please speak with your provider relations consultant if you are interested in scheduling a consultation to learn how to improve quality ratings.

For more information about the quality care initiatives currently underway, please visit www.bcbst.com/providers.

### REMINDER: Medical record acquisition

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage health plans to confirm diagnosis codes submitted on claims are supported in medical records. BlueCross partnered with VeriskHealth and MedSave USA to obtain medical records on our behalf to meet this requirement. VeriskHealth will retrieve records from providers in East Tennessee and MedSave USA for records in Middle and West Tennessee.

Both VeriskHealth and MedSave will formally request medical records twice during 2015. We ask that you please follow the return

instructions provided with the list of requested records. Please recall your BlueAdvantage contract requires the return of these records.

Medical records can be returned to VeriskHealth by either:

- Uploading the record image to the secure portal at https://www.submitrecords.com/ and simply enter your secure password: *bcbst87* then select the files to be uploaded using the file naming convention included in the request letter.
- Faxing to: 1-888-226-3395
- Mailing to:
  **BlueCross BlueShield of Tennessee**
  **10897 S. River Front Parkway**
  **Suite 400T**
  **South Jordan, UT 84095-9984**

Medical records can be returned to MedSave USA by either:

- Faxing to: 1-866-790-4192
- Mailing to:
  **MedSave USA**
  **49 Wireless Blvd, Ste. 140**
  **Hauppauge, NY 11788**
  **Attn: MedSave USA/BCBSTN**

## Chronic care management now available for all Medicare beneficiaries

The Medicare 2015 Physician Payment Rule states that chronic care management is now available for all Medicare beneficiaries as of Jan. 1, 2015. The service is billable under CPT® Code 99490.

Several requirements must be met for this service to be eligible for payment, including;

- Chronic Care Management services must be approved by the beneficiary in advance, in writing.
- Five (5) specific capabilities must be met to qualify for the provision of Chronic Care Management services, including 24/7 access to a care plan.
- These services can only be billed once per month, per patient and must be no less than 20 minutes in duration and directed by a physician or qualified health professional.

Additional requirements are outlined on the Centers for Medicare & Medicaid Services (CMS) website. www.cms.gov/site-search/search-results.html?q=chronic%20care%20management

For additional information please contact the BlueCross Provider Service Line†.

QUALITYCARE REWARDS

## Guidelines for submitting a Patient Assessment Form

In 2015 physicians are again eligible to receive reimbursement for completing and submitting a Patient Assessment Form for their attributed BlueAdvantage and BlueChoice members.

BlueAdvantage will reimburse the service when filed using Evaluation & Management Code 99420 with a maximum allowable charge of:

- $250 for dates of service between Jan. 1 and March 31, 2015
- $200 for dates of service between April 1 and June 30, 2015
- $175 for dates of service between July 1 and Sept. 31, 2015
- $150 for dates of service between Oct. 1 and Dec. 31, 2015

To receive reimbursement, complete the Provider Assessment Form in its entirety and submit electronically via BlueAccess or complete the form available at http://www.bcbst.com/providers/blueadvantage-ppo and return via fax to 1-877-922-2963.

The form should also be included in your patient's chart as part of his or her permanent record.

For additional information about the Patient Assessment Form please visit our website at http://www.bcbst.com/providers/blueadvantage-ppo and www.bcbst.com/providers/quality-initiatives.page

## Health Outcomes Survey focuses on physical activity and improving/maintaining members' physical health

*Physical activity is an important part of staying healthy and maintaining a high quality of life.*

The annual Health Outcomes Survey (HOS), administered by the Centers for Medicare & Medicaid

Services (CMS) as part of provider and payer quality scores, includes two measures focused on physical activity:

- Monitoring physical health
- Improving or maintaining physical health

Members will be asked if their physician has spoken with them in the past 12 months about their level of physical activity. They will also be asked if a physician encouraged them in the last 12 months to increase or maintain their level of physical activity.

It is very important to speak to Medicare Advantage members about the benefits of physical activity on their long-term health.

*These changes will be included in the appropriate 2Q 2015 provider administration manual update. Until then, please use this communication to update your provider administration manual.

**Archived editions of BlueAlert are available online at**

hwww.bcbst.com/providers/newsletters.shtml

## Notes

# Bluealert℠

of Tennessee

## Provider Service Lines†

Featuring "Touchtone" or "Voice Activated" Responses

**Note:** If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

**Commercial Lines** **1-800-924-7141**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**AccessTN/Cover Kids** **1-800-924-7141**
Monday-Friday, 8 a.m. to 6 p.m. (ET)

**BlueCare** **1-800-468-9736**

**TennCare*Select*** **1-800-276-1978**

**CHOICES** **1-888-747-8955**

**BlueCare Plus℠** **1-800-299-1407**

**BlueChoice℠** **1-866-781-3489**

**SelectCommunity** **1-800-292-8196**
Monday–Friday, 8 a.m. to 6 p.m. (ET)

**BlueCard**
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**BlueAdvantage** **1-800-841-7434**

**BlueAdvantage Group** **1-800-818-0962**
Monday–Friday, 8 a.m. to 5 p.m. (ET)

**eBusiness Technical Support**
Phone: Select Option 2 at **(423) 535-5717**
e-mail: eBusiness_service@bcbst.com
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)



of Tennessee
1 Cameron Hill Circle
Chattanooga, Tennessee 37402
bcbst.com

MAY 2015

# BlueAlert℠

## BlueCross BlueShield of Tennessee, Inc.

(Articles apply to all lines of business unless stated otherwise)

**MEDICAL POLICY/GUIDELINES**

### Medical Policy updates/changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

**Effective June 17, 2015**

- Denosumab

**Effective June 13, 2015**

- BioEngineered Skin Soft Tissue
- Complementary and Alternative Medicine
- Multitarget Polymerase Chain Reaction (PCR) Testing for the Diagnosis of Bacterial Vaginosis
- Subcutaneous Implantable Cardioverter Defibrillator

**Note:** These effective dates also apply to BlueCare /TennCare*Select* pending State approval.

## BlueCross BlueShield of Tennessee, Inc.

(Articles apply to all lines of business unless stated otherwise)

### REMINDER: Changes to *BlueAlert* coming soon

In an effort to simplify your interactions with BlueCross, we are excited to introduce a new and innovative way to view the latest publication of the *BlueAlert* provider newsletter on our company websites, www.bcbst.com and bluecare.bcbst.com, The enhanced newsletter will provide an easy-to-navigate electronic format allowing quick access to more information by simply clicking links and hyperlinks referenced in the articles.

Additionally, you will soon be notified via postcard when the new BlueAlert format is available online. Each month, the postcard will highlight important articles that are included in the newsletter and how to access it.

We look forward to providing you with this new upgrade as we move forward in a more efficient, electronic environment.

### COMING SOON: Member scorecards

Soon, members will receive scorecards about preventive screenings that are appropriate for their specific age and gender. The scorecards encourage our members to contact their physician to schedule an appointment to discuss where they stand with their preventive screenings, etc. The scorecard provides members with information related to which screenings may be appropriate, why the screening is important and provides the member with their "status" of the screenings, including which screenings are past due, up-to-date or that need to be completed by the end of the year. The goal is to empower members to play an active role in their health.

**Note:** Scorecards will be mailed to our Commercial, CoverKids, BlueCare Tennessee and BlueCare Plus (HMO)℠ members.

### REMINDER: Physician Quality Information Application available until July 13, 2015

The Physician Quality Information Application on BlueAccess℠ will be available for physician review and self-reporting until July 13, 2015. After July 13, provider ratings will be updated to reflect the self-reported submissions and the updated provider ratings will be included in our provider directories that are available on the company website for our members.

### REMINDER: Avoid claim denials by following prior authorization guidelines

Services rendered without obtaining authorization prior to services being rendered are considered "non-compliant". Prior authorization reviews can be initiated by the member, designated member advocate, practitioner, or facility. However, **it is ultimately the facility and practitioner's responsibility to contact BlueCross to request an authorization.**

When a request for authorization of a procedure, an admission/service or a concurrent review of the days is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the practitioner rendering care for the day(s) or service(s) that have been denied. BlueCross' non-payment is applicable to both facility and practitioner rendering care. The member is held harmless if eligible at the time services are rendered and the covered services are received from a network provider.

When prior authorization is required, providers must obtain authorization prior to scheduled services and within 24 hours or the next business day of emergent services. Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to noncompliance. **BlueCross members cannot be billed for services denied due to non-compliance by the provider.**

## REMINDER: FREE Continuing Medical Education hours! Behaviorally Effective Healthcare in Pediatrics online modules

The Behaviorally Effective Healthcare in Pediatrics (BEHIP) training program is offering **free online Continuing Medical Education (CME) credit!** These training modules provide pediatric health care providers with tools and screening strategies to assess and manage patients with common behavioral health concerns. The eight modules take 30 minutes to one hour to complete and include the following topics:

- Introduction to Behavioral Health in Pediatrics
- Postpartum Depression
- Disruptive Behavior and Aggression
- Inattention
- Anxiety
- Depression
- Substance Abuse
- Coding and Workflow for Behavioral Health

This training opportunity is offered by the Tennessee Chapter of the American Academy of Pediatrics. BEHIP is funded with the support of BlueCare Tennessee.

*This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of Vanderbilt University School of Medicine and the Tennessee Chapter of the American Academy of Pediatrics. Vanderbilt University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.*

For more information, please contact TNAAP Training Coordinator Rebecca Robinson at rebecca.robinson@tnaap.org.

# BlueCare Tennessee

This information applies to BlueCare and TennCare*Select* plans, excluding dual-eligible BlueCare Plus (HMO SNP)SM unless otherwise stated

## Bureau of TennCare offers online Non-discrimination Compliance Training

Non-discrimination Compliance Training is now available to assist providers with understanding federal/state civil rights laws applicable to TennCare and Cover Tennessee Programs. This training tool will also cover the importance of cultural knowledge in health care.

The training is applicable to BlueCare/ TennCare*Select*, CoverKids and BlueCare PlusSM and can be accessed on the following web pages: www.bcbst.com/providers/cover-tennessee.page or bluecare.bcbst.com/Providers/Provider-Education-and-Resources/Training-and-Tools.html.

## Tennessee Health Care Innovation Initiative

Tennessee Health Care Innovation Initiative reports will be available soon and will be based on the provider's Contract Entity rather than the Tax Identification Number. Along with this change TennCare has included the following to the Wave 1 episodes of care reports:

- Stop Loss amounts will be applied in the Overall Performance summary, and
- Rendering provider name, NPI and patient date of birth will be added to the lists of episodes.

To view your reports, please log on to BlueAccess, our secure provider portal. Once in BlueAccess scroll down to Tennessee Health Care Innovation Initiative. You will also see informational reports on the Wave 2 episodes of care, which include:

- Acute COPD exacerbation,
- Screening and surveillance colonoscopy,
- Outpatient and non-acute inpatient cholecystectomy,
- Acute percutaneous coronary intervention (PCI) and Non-acute PCI.

For more information on the Wave 1 and Wave 2 episodes of care, see the State of Tennessee's website at www.tn.gov/HCFA/strategic.shtml.

## Update to Lab Exclusion List

Changes to the *2015 Quest/BlueCare Tennessee Lab Exclusion List* follow:

- Addition of 88341 – Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure

This change is effective May 1, 2015. All other codes remain unchanged.

**Note:** This change also applies to CoverKids members.

## REMINDER: Are you seeing your assigned members?

We are proud to offer you access to the ***NEW*** BlueCross BlueShield of Tennessee Primary Care Provider (PCP) Member Roster application. It is accessible to providers through BlueAccess, our secure provider portal. The PCP Member Roster application has new functionality including searching for providers tied to a group, export and print capabilities. The data is updated weekly. Generally, the turnaround time for PCP changes is within five (5) days; however, due to statewide implementation, we are experiencing a higher than normal volume. If a request has been submitted, please do not resubmit. Your patience is appreciated.

**If the member ID card does not show the correct PCP assignment**, a new feature is available to members offering them the ability to print a temporary ID card to use while they are waiting on a copy of their permanent member ID card. Before denying the patient access to your services, please verify eligibility on BlueAccess and remind them of the temporary ID card feature.

We all know how important it is for PCPs to help coordinate our members' health care needs. As a BlueCare Tennessee PCP, it is your responsibility to verify any BlueCare/ TennCare*Select* member you see is assigned to your patient listing or to another participating PCP in your group *prior* to treatment.

When you treat a member that is not on your PCP Member Roster you will see code WW3 on your remit. Beginning Aug. 1, 2015, this service will be denied when you treat a member that is not assigned to you, a physician in your office or your on-call physician.

## REMINDER: Allowable incontinent supplies

As of July 1, 2014, Budget Reduction Requirements from the Bureau of TennCare requires review of incontinence supplies (diaper products) over 200 per member per month. Therefore, BlueCare Tennessee must perform a retro review of claims that exceed the allowable monthly supply. The review will require the physician order and clinical records supporting the incontinence supply request.

BlueCare Tennessee expects to announce the selection of the supplier of incontinence products on May 15, 2015. Please continue to monitor our website for any updates.

# Medicare Advantage

This information applies to BlueAdvantage℠ HMO/PPO plans, excluding dual-eligible BlueCare Plus℠ unless stated otherwise.

**ADMINISTRATIVE**

## Annual Survey includes questions about member experiences with physicians

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is conducted by the Centers for Medicare & Medicaid Services (CMS) every year and contains several questions directly related to a member's experience with their doctors. The specific questions are:

- In the last six months, when you needed care right away, how often did you get care as soon as you thought you needed?
- In the last six months, how often did your personal doctor explain things in a way that was easy to understand?
- In the last six months, how often was it easy to get appointments with specialists?

The responses CMS receives from Medicare Advantage members become part of BlueCross' network contracted physician's annual STAR quality rating score.

For more information about the CAHPS survey please visit the Quality Care Rewards page on bcbst.com.

## Provider Performance Module data refresh

BlueAdvantage and BlueChoice (HMO)℠ Provider Performance Module data, available in BlueAccess, will be updated at the end of each month instead of the 15th of each month. This will synchronize data updates for all BlueCross products. Additionally, the validation source of the data will be synchronized to minimize variation.

## Risk Adjustment - Key to strong Medicare program

Proper risk adjustment coding and documentation by providers helps strengthen the Medicare program. This ensures accurate attribution of chronic disease conditions and diagnoses are reported to the Centers for Medicare & Medicaid Services (CMS), thereby allowing stratification in health status of enrolled beneficiaries and to allow BlueCross to continue enhancing member benefits and access to care.

The Risk Adjustment methodology also helps BlueCross:

- Identify patients who may benefit from chronic disease and comprehensive case management programs
- Provide support services that enable members to maintain a high quality of life
- Enhance communication throughout the member's health care team

For more information, please see the Provider Performance Module available in BlueAccess.

## Help your Medicare Advantage patients get fit with SilverSneakers

Are your Medicare Advantage patients getting enough physical activity to stay healthy and fit? The Centers for Disease Control and Prevention (CDC) recommends older adults get at least two hours and 30 minutes of activity such as brisk walking every week, plus activity that works the muscles in the legs, hips, back, abdomen, chest, shoulders and arms on two or more days per week.

Medicare Advantage members' annual exams are good times to talk with them about the importance of exercise and help them decide how to be more active. They may ask how to increase activity, how often they should work out, what to expect at a gym or fitness center, and whether there are any restrictions on what they can do.

We encourage you to remind our Medicare Advantage members that they can get the activity they need with the **Healthways SilverSneakers® Fitness Program**, provided for them at **no extra cost**. SilverSneakers offers various options to keep members actively engaged with:

- a fitness membership with access to more than 13,000 fitness locations nationwide, use of all basic amenities, SilverSneakers group fitness classes, fun social activities, and a Program Advisor™;
- SilverSneakers FLEX™ classes at parks, recreation centers and older-adult living communities; and
- online resources such as activity trackers, fitness advice, downloadable recipes and meal plans, and support from the SilverSneakers community.

For more information on the program please visit www.silversneakers.com.

Recommend participation in SilverSneakers, and then challenge each Medicare Advantage member to tell you how much better he or she feels at the next exam!

More information is available on the CDC website at cdc.gov/physicalactivity/everyone/guidelines/olderadults.html.

## Prior authorization requirements for fusion for degenerative joint disease of the lumbar spine

The following documentation is required to request authorization for fusion for degenerative joint disease of the lumbar spine:

- Continued pain and difficulty maintaining activities of daily living (ADLs) despite:
  - activity modification
  - a documented home exercise program or supervised physical therapy
  - anti-inflammatory medication
- Results of pertinent imaging studies, full motor and sensory examination of lower extremities
- Response to conservative treatment, such as injection therapy
- Levels planned for instrumentation

Both Tennessee specific Local Coverage Determination criteria and MCG (formerly Milliman Care Guidelines®) are used to make medical necessity determinations for these services.

## BlueAdvantage looks to curb hospital readmissions

Beginning April 1, 2015, BlueCross rolled out a member facing readmission reduction program that targets BlueAdvantage and BlueChoice members.

Specific discharge diagnoses or extended hospital/skilled nursing stays trigger a call to our member from a BlueCross case manager within 48 hours of discharge. Members are initially assessed to determine any specific barriers to care that could contribute to readmission. If no barriers are identified, their case is closed. If specific barriers to care are present, the case manager works to close the barriers and provides the member with information on physician-recommended follow-up care and medications, along with any needed help scheduling appointments and transportation.

QUALITYCARE REWARDS

## Chlamydia screening

The Centers for Medicare & Medicaid Services (CMS) estimates that almost three million sexually active adolescent and young adult women have chlamydia infections. The majority of women are asymptomatic and if untreated, chlamydia may lead to more serious conditions such as pelvic inflammatory disease, infertility, and ectopic pregnancy. BlueCross monitors quality associated with chlamydia screening.

Women between 16 and 24 years of age, identified as being sexually active should have a chlamydia screening every year. Here are some tips for improving quality with chlamydia screening:

- *Make sure to obtain a sexual history for a girls and young women who could potentially be sexually active. Obtain this history in private without the parent being present.*
- *If you identify a young female patient as being sexually active, perform chlamydia screening annually.*
- *Performing chlamydia screening during a routine cervical cancer screening is also a good idea, but be aware that the National Committee for Quality Assurance (NCQA) does not recommend routine cervical cancer screening for women under the age of 21.*
- *Make sure to code the procedure accurately and timely.*

## Follow-up care for the initial treatment of ADD/ADHD

Stimulant medications prescribed for the treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) may have some serious medical side effects. Best practice is to ensure timely follow up after these types of medications are prescribed. The American Academy of Pediatric & Adolescent Psychiatry (AACAP) recommends the prescribing practitioner follow up after one month of initially prescribing a stimulant type medication for ADD/ADHD. BlueCross monitors quality related to the prescribing of these types of medications. Here are some tips to help you meet the quality standard:

- *Make sure your office staff schedules a follow up visit* **within 30 days** *of the initial diagnosis. If the visit is scheduled outside the 30-day window, it will not meet the standard.*
- *During the summer months, a 90-day supply of medication is sometimes prescribed for the convenience of the family.* **Follow up is recommended prior to end of the 90-day prescription**. *According to the quality measure, a gap of more than 120 days between follow-up visits will mistakenly identify your patient as being "newly diagnosed" (requiring an initial follow-up visit).*
- *Make sure to code the procedure accurately and timely.*

## Colorectal cancer screening

The American College of Gastroenterology (ACG) classifies colorectal cancer screening into two categories, **prevention** and **detection**. According to ACG the preferred colorectal cancer **prevention** screening is colonoscopy and should be offered as the primary test every 10 years, beginning at age 50 and at age 45 years in African Americans.

Please remember to document the results of any colorectal screening test or procedure (unless the documentation is part of the medical history).

Colonoscopy is not available in every clinical setting because of economic limitations and not all patients are willing to undergo colonoscopy for screening purposes. For patients who decline colonoscopy or another cancer prevention test, ACG recommends an annual **fecal immunochemical testing** (FIT) as the preferred colorectal cancer **detection** screening and phasing out the older guaiac-based fecal occult blood testing (gFOBT). A digital rectal exam is NOT counted as evidence of colorectal screening.

Benefits of FIT detection screening includes:

- Superior performance characteristics when compared with older guaiac-based testing
- Requires no dietary restrictions prior to testing
- Single specimen/ease of collection
- Better patient compliance rates

The ordering provider can fax a prescription or send with the patient to either LabCorp* or Quest Diagnostics* patient service centers that are available across the state. The patient will obtain the kit, collect the specimen at home and mail back to the service center in the self-addressed, stamped envelope. More information pertaining to these service centers is available on their websites.

www.labcorp.com/wps/portal/findalab

secure.questdiagnostics.com/hcp/psc/jsp/SearchLocation.do

***Please refer our members to the appropriate in-network lab.**

*Any changes will be included in the appropriate 2Q 2015 provider administration manual update.

**Archived editions of BlueAlert are available online at**

www.bcbst.com/providers/newsletters.shtml.

Do you need help in another language? ¿Habla español y necesita ayuda con esta carta? Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCareSelect 1-800-263-5479. (Arabic); Bosanski (Bosnian) ;(Kurdish-Badinani); (Kurdish- Sorani); Soomaali (Somali); Ngươi Việt (Vietnamese); Español (Spanish) call 1-800-758-1638. Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, or disability. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim? Call 1-800-468-9698 for BlueCare or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues. For TTY help call 771 and ask for 888-418-0008.

# Bluealert℠

of Tennessee

## Provider Service Lines†

Featuring "Touchtone" or "Voice Activated" Responses

**Note:** If you have moved, acquired an additional location, or made other changes to your practice, choose the "touchtone" option or just say "**Network Contracts or Credentialing**" when prompted, to easily update your information.

**Commercial Lines** **1-800-924-7141**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**AccessTN/Cover Kids** **1-800-924-7141**
Monday-Friday, 8 a.m. to 6 p.m. (ET)

**BlueCare** **1-800-468-9736**

**TennCare*Select*** **1-800-276-1978**

**CHOICES** **1-888-747-8955**

**BlueCare Plus℠** **1-800-299-1407**

**BlueChoice℠** **1-866-781-3489**

**SelectCommunity** **1-800-292-8196**
Monday–Friday, 8 a.m. to 6 p.m. (ET)

**BlueCard**
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**BlueAdvantage** **1-800-841-7434**

**BlueAdvantage Group** **1-800-818-0962**
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**eBusiness Technical Support**
Phone: Select Option 2 at **(423) 535-5717**
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BLUECROSS
BLUESHIELD
OF TENNESSEE, INC.

PROVIDER NEWS FLASH

of Tennessee

June 2015

Bluealert SM

# BlueCross BlueShield of Tennessee, Inc.

**Applies to all lines of business unless stated otherwise**

## Medical Policy updates/changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

**Effective July 11, 2015**

- Autonomic Nervous System Testing
- Brachytherapy Breast Cancer
- Responsive Neurostimulation for the Treatment of Refractory Partial Epilepsy

**Note:** These effective dates also apply to BlueCare/TennCare*Select* pending State approval.

## ICD-10 self-help testing tools

Since President Barack Obama signed the Medicare Access and CHIP Reauthorization Act of 2015, most health care organizations seem to be relieved. There were no ICD-10 delay provisions in the legislation. It appears the transition to the updated code-set may actually happen on Oct. 1, 2015.

In our ongoing effort to prepare for the transition to ICD-10, BlueCross is reminding providers of our online, scenario-based ICD-10 testing tools. Providers will be able to choose ICD-10 codes for a number of different scenarios based on their specialty or type of facility. Since this testing program is web-based, online testing tools offer flexibility to be used anytime.

The professional provider testing tool consists of scenarios that are clinical narratives used for ICD-10 coding to detect valid and invalid codes. Providers can view results and compare their answers to other providers in the same specialty.

The institutional provider testing tool consists of medical record numbers that represent high dollar and high volume scenarios from previously processed ICD-9 claims. Providers can recode and compare the associated claims based on ICD-10 coding guidelines.

Check the ICD-10 page on our website http://www.bcbst.com/providers/icd-10.page for access to the ICD-10 testing tools. For questions about the tools and to test with us, please email us at ICD10_GM@bcbst.com.

## Behavioral Health Network being built

BlueCross will assume responsibility for behavioral health contracting and credentialing for its Commercial and Medicare Advantage lines of business beginning Jan. 1, 2016.

Contracts will be sent directly to behavioral health providers in the coming weeks. Professionals can begin preparing for the transition by visiting the website for the Council for Affordable Quality Healthcare, Inc. (CAQH) to ensure credentialing and profile information is complete and current. Please contact your local Behavioral Health Provider Network Manager with any questions.

## NOTICE: National Consumer Cost Transparency data now available

National Consumer Cost Transparency (NCCT) data is currently available for provider review on the BlueAccess SM portal. The Spring 2015 cost data review period will be open through June 27, 2015.

## Health information privacy

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, BlueCross BlueShield of Tennessee makes every effort to protect its members' individually identifiable health information.

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to 1) health plans, 2) health care clearinghouses, and 3) those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives rights to patients over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

Members and patients have the right to access their health information and to know how it is being protected. As such, **BlueCross requests providers maintain a notice of privacy practices and encourages them to publish such notices prominently on their websites.**

## Health Reimbursement Account information

Did you know that you can view member HRA information while checking benefits and eligibility? You will find the HRA Provider Quick Reference Guide on BlueAccess, BlueCross' secure area on its website.

***Note:*** *Contact your eBusiness Marketing Representative for all your BlueAccess registration and training needs.*

*West Tennessee – Debbie Angner*
*Phone: (901) 544-2285*
*Email: Debbie_Angner@bcbst.com*

*Middle Tennessee – Faye Mangold*
*Phone: (423) 535-2750*
*Email: Faye_Mangold@bcbst.com*

*East Tennessee – Faith Daniel*
*Phone: (423) 535-6796*
*Email:Faith_Daniel@bcbst.com*

## Tennessee Rural Health/Farm Bureau Health Plan changes

Tennessee Rural Health (TRH)/Farm Bureau Health Plans will no longer be administered by BlueCross effective with dates of service beginning July 1, 2015. The Medicare Supplement Plans will be administered by TRH in Columbia, TN. Through the Medicare Crossover Program (COBA,) claims will cross to TRH electronically, so there is no need to file a paper claim.

All other TRH plans will be administered by UMR, Inc. Please refer to the member's new ID card for additional information.

## FREE quality training for network providers

BlueCross is offering a two-day class to promote health care quality. The training class is scheduled for Aug. 27 to 28, 2015, and will be held in the BlueCross BlueShield of Tennessee Community Room in Chattanooga, TN. The class is designed to help those planning to take the Certified Professional in Healthcare Quality (CPHQ) examination, and also delivers intermediate quality improvement content that can benefit anyone working in the field of health care quality.

The usual cost for this training is $399, however BlueCross is offering the class to its network providers at no cost. Space is limited, so please contact us soon to register. To qualify for the training you must meet the following criteria:

- ✓ Must currently be employed in a role related to quality improvement or management
- ✓ Must currently be employed by a BlueCross BlueShield of Tennessee network provider
- ✓ Network providers will be limited to submitting two participants per group/facility for the 2015 class

To register e-mail tawanda_malone@bcbst.com.

## The BlueCross BlueShield Association expands Blue Distinction® Specialty Care Program

BlueCross is pleased to announce that the Blue Distinction Specialty Care Program is expanding to include maternity care. Launching in 2016, this designation program will focus on the delivery episode of care, which includes both vaginal delivery and cesarean section.

Similar to other Blue Distinction Centers for Specialty Care programs, selection criteria for the Maternity Care program will be based on quality, business and cost criteria. The evaluation process will use publicly available measures, data sets and quality improvement information, together with cost information derived from BlueCross claims data. Therefore, facilities will not need to apply to be evaluated. After evaluations are completed, facilities will be notified if they meet the program's selection criteria. This is expected to occur in Fall 2015.

A Blue Distinction Center or Blue Distinction Center+ designation signals to your community, patients, and physicians that your facility is committed to quality care, resulting in better overall outcomes for maternity patients. It also offers opportunities for your facility to collaborate with BlueCross to promote the designation locally. On a national level, BlueCross BlueShield Plans and the BlueCross BlueShield Association actively promote Blue Distinction Centers to nearly 104 million members through nationwide public relations efforts, recognition in the National Doctor and Hospital Finder, Blue Distinction Center Finder, and in other communications.

Blue Distinction Specialty Care is a national designation program recognizing health care facilities that demonstrate expertise in delivering quality specialty care safely, effectively and cost efficiently. This program includes two levels of designation:

- Blue Distinction Center: Health care facilities recognized for their expertise in delivering specialty care.
- Blue Distinction Center+: Health care facilities recognized for their expertise and cost efficiency in delivering specialty care. Quality remains key: only those facilities that first meet nationally established, objective quality measures for Blue Distinction Centers will be considered for designation as a Blue Distinction Center+.

For more information, visit www.bcbst.com.

## Obstetric anesthesia*

Obstetric anesthesia for a planned vaginal delivery (01967) that ends in a Cesarean Section delivery (01968) is to be billed on a single claim form using the date of delivery as the date of service. Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code on a separate claim. Add-on codes submitted with no primary code or a different date of service will result in rejection and non-payment of the add-on code.

Obstetric anesthesia services involving more than one provider (e.g. two physicians or two CRNAs) for the same episode are to be submitted on a single claim with the date of delivery as the date of service.

## Transcranial Magnetic Stimulation reimbursement *

Studies have shown that Transcranial Magnetic Stimulation (TMS) treatment may prove successful for reducing symptoms in patients suffering from Major Depressive Disorder (MDD). In order to provide our members with the broadest range of available care, effective July 1, 2015, TMS will be listed as a covered service for all BlueCross business lines. Now we need your help to help ensure treatment is billed properly by:

- Only offering TMS for patients with confirmed cases of MDD, excluding pregnant women and children younger than 18 years of age.
- Ensuring all TMS therapies are administered by a licensed psychiatrist.
- Seeking authorization prior to treating a patient using TMS.
- Applying appropriate CPT® codes for the date of service (DOS) (currently 90867, 90868 and 90869) when reporting cases of TMS treatment.
- Using revenue codes (RCs): 0510, 0513 and 0920 in conjunction with appropriate CPT® codes when services are initiated in an inpatient setting. Please note that charges for TMS filed by a facility during inpatient care are included in the inpatient reimbursement and are **not** paid separately.

Additionally, please review the Reimbursement Policy for Transcranial Magnetic Stimulation, which will appear in the third quarter update to the *BlueCross BlueShield of Tennessee Provider Administration Manual*.

Following these guidelines for TMS therapy will establish consistent reimbursement guidelines, while offering a superior level of care for patients. We appreciate your help and cooperation as we continue to expand our list of covered services.

*CPT® is a registered trademark of the American Medical Association.*

## Low back pain

BlueCare Tennessee is committed to supplying health care providers with important information that supports appropriate utilization of diagnostic imaging studies for low back pain. Clinical guidelines indicate that diagnostic imaging is not necessary for most patients with new-onset low back pain and exposes them unnecessarily to potentially harmful ionizing radiation.

According to the American College of Radiology, uncomplicated low back pain is a benign, self-limited condition that does not warrant any imaging studies. The majority of patients with the condition are back to their usual activities in 30 days. Imaging is considered clinically indicated in patients without improvement after six weeks and for those with a diagnosis of cancer, recent trauma, neurological impairment or intravenous drug abuse.

The challenge for the clinician, therefore, is to distinguish the small segment within this large patient population that should be evaluated

further because of suspicion of a more serious problem. Guidelines from the American College of Physicians and the American Pain Society emphasize a focused history and physical examination; reassurance; initial pain management medications, if necessary; and consideration of physical therapies without routine imaging in patients with nonspecific low back pain. Please be sure to code any secondary or co-morbid condition on claims for imaging tests with a primary diagnosis of low back pain.

## Reminder: Billing for Air Ambulance services

As of May 15, 2015, claims for Air Ambulance Services must be submitted to the BlueCross plan based on the point of pick-up ZIP code rather than the BlueCross BlueShield plan based on your office location.

When billing for these services, submit the ZIP code in Block 32 of the CMS-1500 paper claim form. For ANSI-837p electronic submissions, report the ZIP code in Loop 2310E Segment N4. Claims will be rejected and returned if there is no ZIP code on either of the forms. These claims will also be rejected if the zip code populated in one of the two fields noted above is outside of Tennessee.

If you have questions, please contact your local Provider Relations Consultant.

## Reminder: Credentialing requirements

Professional providers are reminded to update and maintain current information with CAQH®. With the following required information completed and kept up to date, the credentialing process should be seamless:

- Attest to the accuracy of your information with CAQH every 120 days
- Current Certificate of Insurance (BlueCross cannot accept a Declarations Page)
- BlueCross requires call coverage – please complete this section on CAQH
- If the practitioner does not admit to a hospital – BlueCross requires the name of the person authorized to admit for the practitioner
- Complete work history with any gaps in work history explained
- Nurse Practitioners/Physician Assistants: Please upload professional certifications to CAQH.

# BlueCare Tennessee

**This information applies to BlueCare and TennCare*Select* plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise**

## Are you seeing your assigned members?

We are proud to offer you access to the BlueCross BlueShield of Tennessee Primary Care Provider (PCP) Member Roster application. The application is accessible to providers through our secure provider portal, BlueAccess. The PCP Member Roster application has new functionality including searching for providers tied to a group, export and print capabilities. The data is updated weekly.

**If the member's ID card does not show the correct PCP assignment,** members can print a temporary member ID card to use while they are waiting on a copy of their permanent card. Before denying the patient access to your services, please verify eligibility on BlueAccess and remind them of the temporary ID card feature. It is important for PCPs to help coordinate our members' health care needs. As a BlueCare Tennessee PCP, it is your responsibility to verify any BlueCare/TennCare*Select* member you see is assigned to your patient listing or to another participating PCP in your group *prior to treatment*.

When you treat a member that is not on your PCP Member Roster you will see code WW3 on your remittance advice. Beginning Aug. 1, 2015, this service will be denied when you treat a member that is not assigned to you, a physician in your office or your on-call physician.

## Tobacco cessation

According to the 2014 Consumer Assessment of Healthcare Plans and Systems (CAHPS) survey, 24 percent of members reported using tobacco each day—**a 1.6 percent increase over 2013**. Additionally, only 23.4 percent of members who smoke every day or some days reported that their doctor advised they quit using tobacco within the last 12 months.

Follow these tips to help patients kick the nicotine habit:

- Take the time to ask patients who smoke if they are interested in quitting when you visit with them. Engaging patients in a conversation about quitting can be a vital first step toward cessation.
- Provide prescriptions for over-the-counter cessation aids. In some cases, pharmacists instruct patients to discuss cessation with a provider, but do not indicate that a prescription is required to attain nicotine cessation products.
- Suggest alternative agents for patients who experience side effects with cessation aids.
- **DO NOT** suggest or promote the use of e-cigarettes as smoking-cessation aids. These products are

not FDA approved for smoking cessation and any evidence suggesting they are is unproven.
- Direct patients to the Tennessee Tobacco QuitLine at 1-800-Quit-Now (1-800-784-8669) or www.tnquitline.com for cessation support or counseling resources.

If you have questions about BlueCare Tennessee members and smoking cessation, please consult the Frequently Asked Questions document at <http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/Training-and-Tools.html>, call Magellan Health Services at 1-866-434-5524 for prior authorizations or e-mail <TNProviderEducation@magellanhealth.com>.

## Reminder: FREE Continuing Medical Education hours! Behaviorally Effective Healthcare in Pediatrics online modules

The Behaviorally Effective Healthcare in Pediatrics (BEHIP) training program is offering **free online Continuing Medical Education (CME) credit!** Modules provide pediatric health care providers with tools and strategies to screen for, assess and manage patients with common behavioral health concerns. The eight modules range in time from 30 minutes to one hour, covering the following topics:
- Introduction to Behavioral Health in Pediatrics
- Postpartum Depression
- Disruptive Behavior and Aggression
- Inattention
- Anxiety
- Depression
- Substance Abuse
- Coding & Workflow for Behavioral Health

This training opportunity is offered by the Tennessee Chapter of the American Academy of Pediatrics. BEHIP is funded with the support of BlueCare Tennessee.

*This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of Vanderbilt University School of Medicine and the Tennessee Chapter of the American Academy of Pediatrics. Vanderbilt University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.*

For more information, please contact TNAAP Training Coordinator Rebecca Robinson at rebecca.robinson@tnaap.org.

## Reminder: Prior authorization requirement for hyperbaric oxygen therapy

Prior authorization is required for BlueCare and TennCare*Select* members for hyperbaric oxygen therapy. As of Jan., 1, 2015, procedure code C1300 was replaced by GO277 for this therapy.

# Medicare Advantage

## ADMINISTRATIVE

**This information applies to BlueAdvantage℠ HMO/PPO plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise**

## June is Arthritis Awareness month

June is Arthritis Awareness month and a good time to focus on Rheumatoid Arthritis Management as part of the Centers for Medicare & Medicaid Services (CMS) STAR quality rating.

The Rheumatoid Arthritis Management measure focuses on individuals with more than one visit, but different dates of service between Jan. 1 and Nov. 30 of the measurement year.

Patients must also meet the following criteria:
- One or more outpatient visits with any diagnosis of rheumatoid arthritis
- One or more non-acute inpatient discharges with any diagnosis of rheumatoid arthritis

Of the patients meeting the criteria mentioned above, there must be a claim for at least one ambulatory prescription dispensed for a disease-modifying anti-rheumatic drug during the measurement year.

We support you in reminding your patients to fill their prescriptions, especially those related to rheumatoid arthritis treatment, to improve or maintain a high quality of life.

## UPDATE: Medicare Advantage peer-to-peer review prompts just got easier

Phone prompts for scheduling a physician peer-to-peer review for a Medicare Advantage member just got easier. The simplified menu is faster to navigate to help you set up a review and get back to your patients faster.

1. Call 1-800-924-7141.
2. Choose voice by saying “voice” or pressing 1.
3. Select option 1 for providers.
4. Enter your provider ID, NPI or Tax ID.
5. Enter your contact phone number.
6. Press 1 for information on a specific member.
7. Listen to the disclaimer.

8. Say the Member ID number including alpha prefix and verify by pressing 1.
9. Enter the member's date of birth
10. Press 3 for prior authorization and case management.
11. Press 6 to set up a peer-to-peer conversation.

## Register with BlueAccess to view your quality data

The Provider Performance Module is the easiest way to view and update information related to your quality scores for your attributed BlueAdvantage members. If you are not registered for BlueAccess, you can do so by following the instructions listed at the link below.
https://www.bcbst.com/secure/providers/IS-379.pdf.

## Pharmacy savings for BlueElite℠ members

Your BlueElite patients have special access to our Discount Drug Card Program. When patients present their BlueElite card at a participating pharmacy, they will receive the BlueCross negotiated price for their prescriptions.

For a list of participating pharmacies, call the BlueCross Provider Service Line at 1-800-924-7141.

**Reminders:**

- This discount is **not** a Part D benefit and **does not** apply if the patient has a separate Stand-Alone Prescription Drug Plan.
- Ask each patient who administers their Prescription Drug Benefits.
- BlueElite patients without a Part D plan are not eligible for mail-order pharmacy.

## Reminder: Refer lab work to a participating lab provider

Providers are reminded to use in-network options for all laboratory services for BlueAdvantage members, unless the specific laboratory test is not available from a participating lab provider. This includes genetic testing that is covered by Medicare. If the provider refers testing to a non-participating lab and the test was available through a participating provider, then this cost may be the provider's and not the member's responsibility through reconciliation.

## Do you need help in another language?

¿Habla español y necesita ayuda con esta carta? Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479.
العربية *(Arabic);* Bosanski *(Bosnian) ;*
کوردی — بادینانی *(Kurdish-Badinani);*
کوردی — سۆرانی *(Kurdish-Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638.
Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, or disability. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?
Call 1-800-468-9698 for BlueCare or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues. For TTY help call 771 and ask for 888-418-0008.

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| | |
|---|---|
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**BlueAdvantage** **1-800-841-7434**
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Monday–Friday, 8 a.m. to 5 p.m. (ET)

***eBusiness Technical Support***
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
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PROVIDER NEWS FLASH

of Tennessee

July 2015

Bluealert SM

# BlueCross BlueShield of Tennessee, Inc.

**Applies to all lines of business unless stated otherwise**

## Medical Policy updates/changes

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**Effective Aug. 8, 2015**

- Ablation Procedure for Peripheral Neuromas
- IVIG
- Measurement of Serum Antibodies to Infliximab and Adalimumab
- Powered Exoskeleton for Ambulation in Individuals with Lower-Limb Disabilities

**Effective Aug. 19, 2015**

- Ramucirumab

**Note:** These effective dates also apply to BlueCare Tennessee plans pending State approval.

## New drugs added to Commercial Specialty Pharmacy listing

Effective July 1, 2015, the following drugs have been added to our Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

**Provider-administered via medical benefit:**
Signifor Lar (PA)
Unituxin (PA)

**Self-administered via pharmacy benefit:**
Farydak (PA)
Jadenu

Providers can obtain prior authorization for:

- **Provider-administered drugs** that have a valid HCPCS code by logging onto BlueAccess℠, the secure area of www.bcbst.com, selecting Service Center from the Main menu, and clicking Authorization/Advance Determination Submission. If you are not registered with BlueAccess or need assistance, call eBusiness Technical Support†.
- **Provider-administered specialty drugs** that do not have a valid HCPCS code by calling 1-800-924-7141.
- **Self-administered specialty drugs** by calling Express Scripts at 1-877-916-2271.

**NOTE:** BlueCross updates web authorization forms on a quarterly basis. If the HCPCS code is not available now, it may be in the near future.

## Who's My BlueCross Contact?

BlueCross BlueShield of Tennessee recently added a new tool called My BlueCross Contact to the provider page of the company website.

My BlueCross Contact is a reference tool that allows users to search for the field staff representative assigned to a given provider. Users can search by Provider Name or National Provider Identifier (NPI).

Find your representative using the My BlueCross Contact tool located at www.bcbst.com/providers/mycontact.

## All Blue 2015 Provider Workshops…

*Coming Soon to a City Near You!*

The annual state-wide All Blue workshops are designed to simplify your day-to-day interactions with us. Talk with BlueCross professionals who will share important information on current issues. While you are there, visit our Resource Centers and take advantage of one-on-one discussions and breakout sessions. Watch for your invitation in the mail! For additional information including dates, times, locations and easy online registration, please visit our website at bcbst.com/providers/workshops.

## Health information privacy

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, BlueCross makes every effort to protect its members' individually identifiable health information.

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to 1) health plans, 2) health care clearinghouses and 3) those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives rights to

patients over their health information, including rights to examine and obtain a copy of their health record and to request corrections.

Members and patients have the right to access their health information and to know how it is being protected. As such, **BlueCross requests providers maintain a notice of privacy practices and encourages providers to publish such notices prominently on their websites.**

## BlueAccess: Did you know?

You can check the status of your authorizations by simply logging in to BlueAccess℠ and clicking on the **"Authorization/Advance Determination Inquiry"** section from the **"Service Center"** link. An advantage of checking online is not only time saved, but status information related to your inquiry can be printed from the website. Contact your eBusiness Marketing Representative to receive BlueAccess training. Contact information is available in the Provider Service Line† section at the end of this newsletter.

## High-tech imaging change*

As you are aware, utilization management services for all outpatient MRI/MRA/MRS, CT/CTA, PET and Nuclear Cardiac imaging studies are handled by MedSolutions®. Effective July 1, 2015, MedSolutions' name will change to eviCore. All contact information that was previously used for MedSolutions will remain the same.

## Reminder: Tennessee Rural Health/Farm Bureau Health Plan changes

Tennessee Rural Health (TRH)/Farm Bureau Health Plans will no longer be administered by BlueCross effective with dates of service beginning July 1, 2015. The Medicare Supplement Plans will be administered by TRH in Columbia, TN. Through the Medicare Crossover Program (COBA), claims will cross to TRH electronically, so there is no need to file a paper claim.

All other TRH plans will be administered by UMR, Inc. Please refer to each member's new ID card for additional information.

## Late charges*

In the Billing and Reimbursement section of the *BlueCross BlueShield of Tennessee Provider Administration Manual*, the Institutional Claim Billing and Reimbursement Guidelines state: *"BCBST does not accept late charges. To receive consideration for late charges, a corrected claim should be resubmitted."*

Beginning Aug. 1, 2015, Institutional claims (UB04 and 837I) filed with the Type of Bill ending in '5' will be returned with the following rejection:

**150168 – CLM FREQUENCY CODE 5 NOT ACCEPTED**
*Claim Frequency Type Code is located in Loop ID-2300 in the CLM segment. It is the 3rd sub-element of the 5th element. The claim frequency type code 5 is not accepted. This edit is not applicable for BlueCare/ TennCareSelect claims.*

**Claim Status Category Code**
A7 – Acknowledgement/Rejected for Invalid Information – The claim/encounter has invalid information as specified in the Status details and has been rejected.

**Health Care Claim Status Code**
228 – Type of Bill for UB claim

**Note:** This edit does not apply to BlueCare, BlueCare Plus (HMO SNP)℠ or CHOICES.

## Women's Preventive Services: Breastfeeding equipment

In accordance with the Affordable Care Act, BlueCross provides 100 percent coverage for many women's health services. Included in these services are breastfeeding support and counseling, as well as breastfeeding equipment under durable medical equipment (DME) benefits.

Under DME coverage, new mothers have access to certain breast pump devices at no cost. To qualify for full coverage, specific guidelines must be followed, including:

- Mothers are eligible for one manual breast pump in conjunction with each birth.
- A physician's prescription is required when purchasing a breast pump through a participating DME supplier.
- Electric breast pumps will be covered up to the maximum allowable charge of manual breast pumps.
- Electric breast pumps may be covered by certain employer groups. Please call and verify these benefits prior to supplying electric pumps to ensure members are informed of the potential for higher cost shares.
- Manual pumps purchased from retail stores and in-network DME providers receive 100 percent in-network preventive benefits not subject to deductible or copayment.
- The amount allowed toward any breast pump of choice, whether manual, electric or hospital grade, regardless of where purchased, will not exceed applicable DME allowances for standard manual pumps. Members will be liable for any cost difference.

Please note that pump replacement supplies are **NOT** covered by BlueCross.

## DME: Did you know?

If you are a BlueCross Commercial provider, don't miss out on this durable medical equipment (DME) processing tip:

*By renting or renting-to-buy CPAP/BIPAP equipment, you can **avoid prior authorization processing** since the cost of renting the equipment is less than the $500 DME limit. Keep in mind, the purchase price for equipment is considered reached after only 10 months' rental, but if you elect to buy early, prior authorization **will be** required.*

Be sure to take advantage of this option to save yourself and your staff time and frustration, while continuing to offer your patients superior care!

# BlueCare Tennessee

**This information applies to BlueCare and TennCare*Select* plans, excluding dual-eligible BlueCare Plus (HMO SNP)SM unless stated otherwise**

## Important notice from the Bureau of TennCare for BlueCare, TennCareSelect and CoverKids Providers

BlueCare Tennessee recently notified you about changes outlined in the State of Tennessee 2016 fiscal year budget. The Bureau of TennCare also released an updated memorandum providing specific guidance regarding changes in rates/reimbursements for TennCare Managed Care Organizations (MCOs).

**Please note: There was not a 1 percent rate reduction that went into effect July 1, 2015. The only rate changes was for the therapy codes listed in the original notification.**

Visit our website at http://bluecare.bcbst.com for the complete memorandum provided by the Bureau.

Thank you for your continued commitment to providing quality care for BlueCare, TennCare*Select* and CoverKids members.

## New management for incontinence products

On Oct. 1, 2014, BlueCare Tennessee published a request for proposal (RFP) for incontinence products to ensure effective management of quality products for all BlueCare members in Tennessee and contiguous counties. After taking all evaluation criteria into consideration, BlueCare Tennessee is pleased to announce it will award Medline Industries the contract for incontinence products. BlueCare Tennessee believes Medline's approach to quality of care and affordable pricing supports our vision for the wellbeing of our members.

BlueCare Tennessee is targeting an effective date of Aug. 1, 2015, for the contract with Medline Industries. Additional information regarding our transition plan to ensure BlueCare members continue getting the products they need during this transition will be forthcoming.

Thank you to the providers who responded to the RFP for incontinence products. BlueCare Tennessee appreciates your participation and interest in meeting this community's need.

## Hysterectomy form update *

The Bureau of TennCare has updated the Medicaid – Title XIX Acknowledgement of Hysterectomy Information Form. The form was revised for clarity to ensure providers complete only one section of the form. As of Aug. 1, 2015, the form will no longer be accepted if more than one section is completed.

All Abortion, Sterilization, and Hysterectomy (ASH) forms, along with instructions for completion, are available online at http://bluecare.bcbst.com/Providers/Provider-Education-and-Resources/Forms.html under Authorization and Notification Forms.

## myBLUE PCP

myBLUEPCP is the new name for BlueCare Tennessee's Primary Care Providers (PCP) Assignment program.

**Beginning Aug. 1, 2015**, PCPs will not be reimbursed for providing services to members who are not assigned to them. It is important your covering logic is correct.

- All participating PCPs within the same provider group will be systematically loaded as covering for each other.
- All PCPs that are under the same tax ID but in different groups can be loaded as covering for each other based on information received from your office.
- All PCPs without group affiliation will be manually loaded with covering provider information based on information provided by their offices.

**To ensure Covering Information is correct:**

- Call our Provider Service line† at 1-800-924-7141 and select option 1.
- Submit your covering provider listing on business letterhead via fax to (423) 535-3066 or to (423) 535-5808.
- Mail your covering provider listing on business letterhead to:

  BlueCross BlueShield of Tennessee
  1 Cameron Hill Circle
  Chattanooga, TN 37402-0001
  Attention: Provider Network Enrollment 2.4

**Look for more information coming soon to all participating PCPs.**

## Pre-teens and teens need vaccines, too!

**Encourage parents to plan vaccinations for their preteen or teen this summer. Remind them to make an appointment before the back-to-school rush begins.**
As you know, there are four vaccines recommended for preteens and teens—
**1 dose Meningococcal Vaccine**
**1 dose Tdap/Td Vaccine**
**3 doses of HPV Vaccine (within a six-month period)**
**Influenza (flu) vaccine**

These vaccines help protect children, their friends, and their family members. While kids should get a flu vaccine every year, the three other preteen vaccines should be given when kids are 11- 12 years old. Teens may also need a booster of a vaccine that requires more than one dose to be fully protected.

**Tips to improve immunization rates and keep your parents informed:**

- Make sure adolescents turning 13 complete all doses of the recommended 4 immunizations BEFORE their 13th birthday.
- Discuss the importance of adolescent preventive care. Give parents a copy of a current immunization schedule and information on the different vaccines, dosages, and what they prevent, along with a reputable source to reference (www.cdc.gov/vaccines )
- Provide parents with an up-to-date shot record that they can keep for their own documentation.
- Schedule next adolescent well-care appointment before leaving the office.
- Create a "tickler file" and send reminder letters, calls prior to appointments.
- Follow up on missed appointments so that rescheduling can occur.
- Look for each opportunity to immunize adolescents apart from just vaccination appointments. If you have a child in your office already for a well-visit, or to complete a camp physicals, schools physicals, etc. consider offering immunizations at that time.
- Make sure to code the procedure accurately and timely.

## Prior authorization update

Beginning Aug. 1, 2015, prior authorization will be required for BlueCare and TennCare*Select* members for the following HCPCS Codes for implantable neurostimulator for chronic pain management:

- **C1767**: generator, neurostimulator (implantable), nonrechargeable
- **C1778**: lead neurostimulator (implantable)

# Medicare Advantage

# ADMINISTRATIVE

**This information applies to BlueAdvantage℠ HMO/PPO plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise**

## Avoid non-compliance services requiring prior authorization

Failure to meet prior authorization requirements can result in claims denial or reduced benefits for services. Remember that many of these requirements originate from the Centers for Medicare & Medicaid Services (CMS). CMS prior authorization guidelines are available at the following link.
http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Prior-Authorization-Initiatives-.html

## Annual documentation for members receiving hemodialysis

To better coordinate coverage for dialysis services, beginning Aug. 1, 2015, nephrologists and dialysis providers are required to submit an **End State Renal Disease Medical Evidence Report – Medicare Entitlement and/or Patient Registration** (CMS-2728 form) each year for Medicare Advantage members receiving hemodialysis services. This form is located at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS2728.pdf and should be faxed to Medicare Advantage Care Management at 1-888-535-5243.

## New Medicare Advantage Part B drugs

New injectable and infusible drugs are approved periodically by the Food and Drug Administration (FDA). These drugs are researched to determine if the drug is considered by the Centers for Medicare & Medicaid Services (CMS) to be a Part B or a Part D drug for benefit coverage.

The following are new Medicare Advantage Part B drugs that require prior authorization according to Medicare National Coverage Determination (NCD) or Local Coverage Determination (LCD) criteria:

| Brand Name | Generic Description | JCode |
|---|---|---|
| Blincyto | Blinatumomab | J9999 |
| Keytruda | Pembrolizumab | J9999 |
| Lemtrada | Alemtuzumab | J3590 |
| Opdivo | Nivolumab | J9999 |

The full list of 2015 Medicare Advantage Part B drugs that require prior authorization is available on our Medicare Advantage provider website at:
http://www.bcbst.com/providers/medicare-advantage/2015-Medicare-Advantage-Specialty-Pharmacy-List.pdf

## Reimbursement for oxygen equipment follows Medicare guidelines

As required by the Centers for Medicare & Medicaid Services (CMS), Tennessee Local Coverage Determination L11446 and the supporting policy article A33750 released in Oct. 2014, reimbursement for oxygen equipment is limited to 36 monthly rental payments. Payment for accessories, delivery, back-up equipment, maintenance and repairs is included in the rental reimbursement.
The supplier providing oxygen equipment for the first month must continue to provide any necessary oxygen equipment and all related items and services through the 36-month period. Content (oxygen) will continue to be reimbursed beyond the 36 months.

After 36-monthly rentals have been reimbursed there will be no further payment for oxygen equipment during the five year reasonable use lifetime of the equipment. The supplier who provided the equipment during the 36-month rental is required to continue providing the equipment during the five year reasonable use lifetime of the equipment.

Please refer to this website for exceptions and additional information. http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=33750&ver=36&ContrId=140&ContrVer=2&LCDId=11446&CntrctrSelected=140*2&Cntrctr=140&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&DocType=Active&LCntrctr=140*2&IsPopup=y&

QUALITYCARE REWARDS

**This information applies to all lines of business unless stated otherwise**

## Medication adherence for diabetes medications – CMS quality measure

One of the most important ways our members can manage their health is by taking their prescribed medications. The Medication Adherence for Diabetes Medications quality measure is defined as the percentage of Medicare Part D beneficiaries who adhere to their prescribed oral antidiabetic and GLP-1 receptor agonist drugs.

To arrive at the adherence target, the Centers for Medicare & Medicaid Services (CMS) divides the number of beneficiaries on targeted diabetes medications with a proportion of days covered (PDC) of at least 80 percent (numerator) by the total number of beneficiaries with at least two fills of a targeted drug during the calendar year (denominator). CMS compares our Medicare Advantage health plans to all other plans on this and all STAR measures.

The PDC is the percentage of days in the measurement period "covered" by prescription claims for the same medication(s). Patients are only included in the measure calculation if the first fill of their medication occurs at least 91 days before the end of the enrollment period.

## In-home test kits available for homebound members

We know that getting to the doctor's office can sometimes be a challenge for Medicare Advantage members. BlueCross offers in-home test kits for three of the most common screenings needed by Medicare Advantage.

Our partnership with Home Access requires a simple telephone call to 1-866-435-4372 and the member will be mailed an in-home test kit for:

- fecal occult blood screening for colorectal cancer
- kidney function screening for diabetic patients
- HbA1c blood test for diabetic patients

The member then follows the instructions to mail the kit back to the vendor for lab testing. Written results are then shared with the provider and the member. The screenings are free to the member and count towards the provider's practice quality rewards incentive for attributed members.

For more information on how to order an in-home test kit, contact Julie Thomas at (423) 535-6827.

## Document weight assessment and counseling!

You've probably heard the old adage, "If it didn't get documented, it didn't get done." This holds true for weight assessment and counseling. According to the Centers for Disease Control and Prevention (CDC), childhood obesity has more than doubled for children and tripled in adolescents in the past 30 years. Assessment and counseling related to weight play a key role in addressing this problem. However, monitoring this important health intervention is impossible unless you document! The National Committee for Quality Assurance measures the percentage of children ages 3 to 17 who receive the following during an outpatient visit:

- BMI percentile documentation
- Counseling for nutrition
- Counseling for physical activity

It is important that these services are being performed and documented.

**Important tips and reminders:**

- **Check boxes** on your paper encounter forms make it much easier to document.
- If you use Electronic Medical Records (EMR), be sure weight assessment and counseling documentation functions are active.
- Record BMI percentage (not absolute BMI) for children under 16 years of age.
- Date all forms.
- Document any materials related to diet and nutrition you may offer to your patients.

## High-risk medications

BlueCross continually works to improve treatment outcomes and patient safety for members enrolled in its Medicare Advantage products (BlueCare Plus, BlueChoice and BlueAdvantage). The Centers for Medicare & Medicaid Services (CMS) endorses several important patient safety measures. One of these measures, high-risk medications, includes therapeutic categories linked with potential health risks when used by patients over age 65. Some of the most commonly prescribed high-risk medications include zolpidem tartrate, muscular relaxants, estrogen-containing products, hydroxyzine, amitriptyline, doxepin and nitrofurantoin. When used by patients over 65 years old, these medications have been shown to be associated with higher risk of adverse effects. The good news is there are therapeutic alternatives for most of these high-risk medications. In 2015, we may periodically notify you when one of your patients fills a high-risk drug prescription. If appropriate, please consider if the patient can be treated with a safer alternative.

We have also developed a list of the most common high-risk medications and therapeutic alternatives that you may consider. This reference is posted on our provider portal and can be accessed at http://bluecareplus.bcbst.com/docs/providers/High_Risk_Medication_Therapeutic_Alts.pdf

## Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. العربية *(Arabic);* Bosanski *(Bosnian) ;* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish-Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638.

Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, or disability. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?
Call 1-800-468-9698 for BlueCare or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues. For TTY help call 771 and ask for 888-418-0008.

***** These changes will be included in the appropriate 3Q 2015 provider administration manual update.

**Archived editions of BlueAlert are available online at** <http://www.bcbst.com/providers/newsletters.shtml>.

## †Provider Service lines

***Featuring "Touchtone" or "Voice Activated" Responses***

**Note:** If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or just say **Network Contracts or Credentialing** when prompted, to easily update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

**Commercial Lines** **1-800-924-7141**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**AccessTN/Cover Kids** **1-800-924-7141**
Monday–Friday, 8 a.m. to 6 p.m. (ET)

| | |
|---|---|
| **BlueCare** | **1-800-468-9736** |
| **TennCare*Select*** | **1-800-276-1978** |
| **CHOICES** | **1-888-747-8955** |
| **BlueCare Plus℠** | **1-800-299-1407** |
| **BlueChoice℠** | **1-866-781-3489** |
| **SelectCommunity** | **1-800-292-8196** |

Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

**BlueCard**

| | |
|---|---|
| Benefits & Eligibility | **1-800-676-2583** |
| All other inquiries | **1-800-705-0391** |

Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

| | |
|---|---|
| **BlueAdvantage** | **1-800-841-7434** |
| **BlueAdvantage Group** | **1-800-818-0962** |

Monday–Friday, 8 a.m. to 5 p.m. (ET)

***eBusiness Technical Support***
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

of Tennessee

August 2015

Bluealert SM

# BlueCross BlueShield of Tennessee, Inc.

**Applies to all lines of business unless stated otherwise**

## Medical Policy updates/changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

**Effective Sept. 13, 2015**
- Artificial Pancreas System Device
- Pharmacogenetic Testing for Pain Management
- Positron Emission Testing for Oncologic Applications

**Effective Sept. 16, 2015**
- Obinutuzumab
- Tbo-Filgrastim
- Transcranial Magnetic Stimulation , Cranial Electrotherapy Stimulation and Navigated Transcranial Magnetic Stimulation *(Revised Policy)*

**Note:** These effective dates also apply to BlueCare Tennessee pending State approval.

## New drugs added to Commercial Specialty Pharmacy listing

Effective July 1, 2015, the following drugs have been added to our Specialty Pharmacy drug list. Those requiring prior authorization are identified by (PA).

**Self-administered via pharmacy benefit:**
Cholbam
Natpara

Providers can obtain prior authorization for:
- **Provider-administered drugs** that have a valid HCPCS code by logging onto BlueAccess, the secure area of www.bcbst.com, and selecting Service Center from the main menu, followed by "Authorization/Advance Determination Submission." If you are not registered with BlueAccess or need assistance, call eBusiness Technical Support†.
- **Provider-administered specialty drugs** that do not have a valid HCPCS code by calling 1-800-924-7141.
- **Self-administered specialty drugs** by calling Express Scripts at 1-877-916-2271.

NOTE: BlueCross updates web authorization forms on a quarterly basis. If the HCPCS code is not available now, it may be in the near future.

## Reminder: All Blue 2015 Provider Workshops

*Coming Soon to a City Near You!*

The annual state-wide All Blue workshops are designed to simplify your day-to-day interactions with BlueCross. Talk with BlueCross professionals who will share important information on current issues. While you are there, visit our Resource Centers and take advantage of one-on-one discussions and breakout sessions.

For additional information including dates, times, locations and easy online registration, please visit our website at bcbst.com/providers/workshops.

## Tennessee Health Care Innovation Initiative

Tennessee Health Care Innovation Initiative (THCII) August reports will be available Aug. 7, 2015. To review your August THCII reports, please log into BlueAccess[SM] at www.bcbst.com by clicking the Log In/Register link found at the top right hand corner of the page. If you have not registered for BlueAccess, the site will guide you through the registration process.

The THCII August report titles have been updated to help you choose the report you would like to review. The report titles are:

**Preview without Thresholds**
Informational report without cost or quality thresholds

**Preview with Thresholds**
Preview report with cost and quality thresholds

**Interim Performance**
Interim performance report for contracted lines of business: BlueCare, TennCare*Select* and CoverKids in a performance period

**Final Performance**
Final performance report for contracted lines of business: BlueCare, TennCare*Select* and CoverKids

THCII Preview reports will be available for each new episode of care prior to the performance period. Each episode of care performance period begins on Jan. 1 and ends Dec. 31 of each year with Performance reports released each quarter.

For more information about the Tennessee Health Care Innovation Initiative episodes of care, visit the State of Tennessee website at https://tn.gov/hcfa/section/strategic-planning-and-innovation-group.

## DME authorizations online

Durable Medical Equipment (DME) authorizations may now be submitted through BlueAccess. You can attach medical records, invoices, and certificates of medical necessity as required by the Centers for Medicare & Medicaid Services to the DME authorization request and on the Clinical Update form.

***Note:*** *Contact your eBusiness Marketing Representative for all your BlueAccess registration and training needs.*

*West Tennessee – Debbie Angner*
*Phone: (901) 544-2285*
*Email: Debbie_Angner@bcbst.com*

*Middle Tennessee – Faye Mangold*
*Phone: (423) 535-2750*
*Email: Faye_Mangold@bcbst.com*

*East Tennessee – Faith Daniel*
*Phone: (423) 535-6796*
*Email: Faith_Daniel@bcbst.com*

## Coming Changes to Musculoskeletal Program

Changes are coming soon to the BlueCross Musculoskeletal Program for Commercial and Medicare Advantage lines of business. Please see additional information in upcoming issues of the BlueAlert newsletter and also in the Provider Section of the company website, www.bcbst.com.

## Help improve childhood & adolescent immunization rates

In spite of recent "mixed messages" in the media, most parents understand the importance of childhood & adolescent immunizations. However, busy schedules sometimes make it difficult for parents to get their kids to the doctor's office according to vaccination schedule recommendations. **Encourage parents to plan vaccinations for children before the back-to-school rush begins.**

**Children under 2 years old:**
It is important that you schedule appointments for children to complete all doses of the 10 recommended immunizations by 23 months of age.

| | | |
|---|---|---|
| **4 DTaP** | **3 HiB** | **1 Varicella** |
| **1 MMR** | **2 OR 3 RV** | **3 IPV** |
| **3 HepB** | **4 PCV** | **1 HepA** |
| **2 Initial Influenza & Yearly thereafter** | | |

**Adolescents 11-12 years of age:**
There are four vaccines recommended for preteens and teens—**1 dose Meningococcal, 1 dose Tdap/Td Vaccine, 3 doses of HPV Vaccine (within 6 month period), and the influenza (flu) vaccine.** While kids should get a flu vaccine every year, the three other preteen vaccines should be given when kids are 11- 12 years old.

**Recommended steps to help improve childhood & adolescent immunizations:**

- Review shot records of children 23 months of age and younger to help ensure the 10 recommended immunizations have been received or are scheduled to be received.
- Review the shot records of your adolescent patients under the age of 13 to ensure they have received all doses of the three recommended vaccines and their yearly flu shot prior to their 13th birthday.
- Discuss the importance of childhood preventive care. Give parents a copy of a current immunization schedule and information on the vaccines, such as dosage and use, along with a reputable source reference (i.e. www.cdc.gov/vaccines)
- Provide parents with an up-to-date shot record that they can keep.
- Schedule an appointment for the next immunization or check-up due before the child leaves the office.
- Send reminder letters and make phone calls prior to appointments.
- Follow up on missed appointments so that rescheduling can occur.
- Look for each opportunity to immunize children apart from just vaccination appointments. If you have a child in your office already for a visit, consider offering immunizations at that time.
- When billing, be sure to code administered immunizations accurately and in a timely manner.

**Note:** If you provide care for BlueCare or TennCare*Select* members ages 18 or younger, you are eligible to receive free vaccine serums from the Tennessee Department of Health's Vaccines for Children (VFC) Program. For more information, call 1-800-404-3006, Monday through Friday, 8 a.m. to 4:30 p.m. (CT).

## IMPORTANT REMINDER


## Managing your COPD patients

As we head into the colder months respiratory illnesses and flu are right around the corner. It is important to keep your Chronic Obstructive Pulmonary Disease (COPD) patients as healthy as possible and out of the emergency department and hospital. A few simple steps can help:

- Schedule an immunization visit for your COPD patients for flu and pneumonia vaccines (as applicable) before flu season starts.
- Make an appointment with your COPD patients to develop a COPD action plan (www.lung.org) and discuss their medication regimen before flu season starts.
- Ask questions to determine your patients' understanding of their current COPD medications at each visit.

Encourage your patients to use a COPD checklist and bring it to each appointment. (The checklist is available on COPD.com at http://www.copd.com/copd-tools-resources/copd-checklist.html.)

Educate your patients that:

- Systemic Corticosteroids can shorten recovery time, improve lung function and reduce the risk of early relapse, treatment failure and length of hospital stay.
- Short-acting inhaled Beta2-agonists with or without anticholinergics should be used for treatment of an exacerbation.

Clinical Practice Guidelines: Global strategy for the diagnosis, management and prevention of COPD is available at: http://www.goldcopd.org/guidelines-global-strategy-for-diagnosis-management.html

## Reminder: Refer lab work to a participating provider

Providers are reminded to use BlueCross in-network options for all laboratory services for our members unless the specific laboratory test is not available from a participating lab provider. This includes genetic testing that is covered by Medicare. If our members are referred to a non-participating lab for testing and the test was available through a participating provider, then through reconciliation, the cost may be the responsibility of the referring provider and not the member.

## Behavioral health case managers natural fit in overall care

In the context of behavioral health management, case managers play an essential role in ensuring the overall health and wellbeing of patients—which can prove extremely valuable for providers. Case managers work one-on-one with patients to navigate care processes and ensure needs are met. Starting with an initial patient meeting, case managers gather information from all providers involved in an individual's care and obtain appropriate releases to facilitate coordination.

Once care facilitation is approved, case managers work with patients to:

- Assess care needs and strengths
- Identify treatment goals
- Develop a care or treatment plan
- Research supportive services or groups
- Coordinate care
- Monitor quality of care received

Case managers engage patients in the management of their physical and mental health, which contributes to positive outcomes and helps maximize each individual's potential for recovery and better overall quality of life. For behavioral health providers, case managers can seamlessly integrate into a practice and potentially prove significant dividends in terms of quality of outcomes and patient satisfaction.

# BlueCare Tennessee

**This information applies to BlueCare and TennCare*Select* plans, excluding dual-eligible BlueCare Plus (HMO SNP)SM unless stated otherwise**

## BlueCare claim status checks

The Interactive Voice Response (IVR) system allows BlueCare Tennessee providers to receive claims status updates in minutes over the phone!

To check the status of a claim over the phone, follow these simple steps:

1. Call 1-800-468-9736 for BlueCare and 1-800-276-1978 for TennCare*Select* and enter your provider ID and contact number.
2. When prompted, say "member" for information related to a specific member.
3. Say the member ID number including all alphabetical characters.
4. Say the member's date of birth in the order of month, date and year.
5. Say "medical" for the subscriber's medical information.
6. For automated claim status, say "claim status."

Once this process is complete, the IVR system will collect the Date of Service, look up the claim and read claim status information back to you.

In addition to calling in to the IVR system, claims status updates may be obtained online by logging into BlueAccess.

## Eventa services available for members receiving respiratory care

BlueCare Tennessee is pleased to announce a new partnership with Eventa, LLC, as of July 1, 2015, to provide technical expertise for our adult and pediatric members receiving enhanced respiratory care in a home, community or inpatient setting. Eventa will also provide onsite practitioners to assist in monitoring the quality of care provided by our contracted nursing facilities as required by our TennCare contract.

**Note:** This does not apply to CoverKids.

## TENNderCare Program gets a new name

As of June 5, 2015, TENNderCare, TennCare's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program for members under the age of 21 years has changed its name to **TennCare Kids**.

Tennessee has a commitment to promoting good health in children from birth until age 21 years.

**TennCare Kids** is a full program of checkups and health care services for children who have TennCare. These services make sure babies, children, teens and young adults receive the health care they need. TennCare covers services needed to find or treat medical, dental or behavioral health problems.

The links below will direct you to helpful resources:

- *Bright Futures/American Academy of Pediatrics Periodicity Schedule*
- *CDC Immunization Schedules*
- *Tennessee Chapter of the American Academy of Pediatrics (TNAAP)*
- *Tennessee Department of Health (TDH) Immunization Program*
- *TDH Required Immunizations*

## Update: Outpatient surgery observation billing guidelines

BlueCare Tennessee has announced changes to billing guidelines for outpatient surgery observation.

BlueCare Tennessee **will** consider reimbursement for outpatient observation services for members, who, after six hours of recovery for outpatient services, are not medically stable for discharge. BlueCare will base the observation time on when the member arrives in a designated observation bed and when he/she leaves observation, after the six-hour recovery time, if applicable.

## Reminder: Medically Unlikely Edits

The CMS National Correct Coding Initiative in Medicaid (NCCI) exists to ensure appropriate billing methodologies for Medicare Part B and Medicaid claims. Left uncorrected, coding errors in such claims can result in inappropriate payments.

The NCCI contains two types of edits to help reduce coding errors. One group of these edits is referred to as **Medically Unlikely Edits (MUEs)**, which are defined as: *The maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service for each Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT®) code.*

BlueCross defers to the Medicaid standard procedure for managing MUEs, as follows:

- The UOS reported for the HCPCS/CPT® code on the claim line is compared to the MUE value for that code.
- If the UOS on the claim line is less than or equal to the MUE value assigned to the HCPCS/CPT® code, the units of service billed pass the MUE and are considered for reimbursement.
- If the UOS on the claim line is greater than the MUE value assigned to the HCPCS/CPT® code, the UOS fails the MUE and the entire claim line is denied. That is, no unit of service will be paid for the code reported on that claim line.

For more information about MUEs or the NCCI, visit www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html.

*CPT® is a registered trademark of the American Medical Association.*

## BlueCare Plus (HMO SNP) SM Model of Care

Each year, BlueCare Plus℠ is required to perform an annual evaluation of its Model of Care. This evaluation assesses the overall effectiveness of the *BlueCare Plus Tennessee 2014 Model of Care and Quality Improvement Program Plan*. The overall goals for the Quality Improvement Program were successfully achieved in 2014. Some of the 2014 key accomplishments include:

- CMS approval for Quality Improvement Project (QIP) implementation in 2015
- CMS approval for Chronic Care Improvement Program (CCIP) implementation in 2015
- Proactively reviewed and implemented CAHPS and Provider Satisfaction Survey interventions
- Engaged 82 percent of membership in Care Coordination
- Successfully implemented a Readmission Prevention Program in Hamilton and Shelby counties, and surrounding areas, to include an in-hospital visit during admission and home visits after discharge

The *2014 BlueCare Plus Model of Care & Quality Improvement Program Plan*

*Evaluation* was reviewed and approved by the BlueCare Tennessee Board of Directors on May 4, 2015. To obtain a copy of the full report contact BlueCare Plus at 1-800-299-1407.

# Medicare Advantage

## ADMINISTRATIVE

**This information applies to BlueAdvantage℠ HMO/PPO plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise**

## Did you know?

You can check the status of your authorization by simply logging in to BlueAccess and clicking on the **"Authorization / Advance Determination Inquiry"** section from the "Service Center" link? An advantage of checking online is not only time saved, but you can also print your status from the website. If you are interested in training, please contact your eBusiness Marketing Representative. Their contact information is located at the end of this newsletter.

## Help us decrease turn-around time for authorization requests

BlueCross is working hard to decrease the turn-around time for post-acute care facility authorization reviews. For a faster response, be sure to provide the following information with your requests:

- Prior level of function (members physical/mental state prior to the acute illness/hospitalization)
- Member living arrangements
- Current level of function as evaluated by physical and occupations therapists
- Projected discharge date with care plan

Including this information with your authorization requests will help us provide a response more quickly.

## Oxygen rentals require Certificate of Medical Necessity

In order to make sure BlueAdvantage and BlueChoice (HMO)[SM] have all the data needed to make a determination of medical necessity, and to keep members from being charged for medical equipment not covered under their plan, BlueCross requires that a certificate of medical necessity (CMN) be filed with all authorization requests for oxygen rentals.

In the past, up to 30 days were allowed for providers to submit the CMN documentation; however, sometimes this resulted in delays after the first month, leaving the member to receive service denials some months later. Submitting a CMN at the time of the initial authorization request for the equipment will help ensure that the service is reviewed for medical necessity up front, thus ensuring that the agency will be paid for all services rendered and the member won't be billed. This change will also help us comply with rules set forth by the Centers for Medicare & Medicaid Services on oxygen rentals for Original Medicare, which implemented a model requiring a CMN for all oxygen rentals.

## Reimbursement for oxygen equipment

As mandated by the Centers for Medicare & Medicaid Services (CMS), Tennessee Local Coverage Determination L11446 and the supporting policy article A33750 released in October 2014, monthly reimbursement for oxygen and oxygen equipment is limited to 36 months of continuous use. Reimbursement for oxygen rental includes equipment, contents, accessories, supplies, delivery, back-up equipment and maintenance and repairs.

After 36 monthly rental payments have been made there are no further payments for oxygen equipment during the following 5-year reasonable use lifetime of the equipment. The supplier who provided the equipment during the 36-month rental is required to continue providing the equipment during the 5-year reasonable use lifetime of the equipment.
Please refer to the CMS website for exceptions and additional information.
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1103.pdf

## Provider Performance Module updates improved convenience, effectiveness

In response to feedback from providers, BlueCross recently made enhancements to it's Provider Performance Module (PPM) that provides more detailed information, ease of use and increased functionality.

Some improvements include:
**Member Roster** – You can see the number of open gaps for your members and a list of non-compliant members by measure.

**Financial Summary** – The Patient Assessment Form (PAF) tiered reimbursement schedule has been added to the right side of the page and Quality Rewards Actual and Opportunity are now represented as patient counts on the left side of the page.

**Online PAF** – You can access the online PAF on the Member page of our website, navigate the user-friendly document and complete and submit the form online.

To synchronize data updates across all BlueCross products, updates to the Medicare Advantage PPM now occur at the end of each month.

For more information please visit the website at
https://www.bcbst.com/secure/providers/index.shtml

QUALITYCARE REWARDS

**Applies to all lines of business unless stated otherwise**

## Schedule a bone density test within six months after a fracture

Often the first symptom of osteoporosis in an older patient is a broken bone. Because seniors, especially senior women, are susceptible to osteoporosis, it is important to schedule a bone density test for any Medicare Advantage patient who has suffered a fracture.

According to the Centers for Medicare & Medicaid Services, women between the ages of 67 to 85 who have had a fracture should receive either a bone density test or prescription to treat osteoporosis (if documented) within six months post fracture.

**Best Practices**

- Advise your patients to include adequate amounts of calcium in their diets.
- Recommend regular weight-bearing exercise like walking or dancing.
- Talk to your patients about risk factors for falls.
- Measure height annually.
- Perform a bone mineral density test on women 65 years old and older and men age 70 and older.
- Prescribe appropriate medication for patients with a hip or vertebral fracture.

## Maintaining quality of life with early intensive treatment of Rheumatoid Arthritis

In 2012, the American College of Rheumatology updated their recommendations, outlining an aggressive approach to treating rheumatoid arthritis patients to improve their quality of life and control disease progression.

According to the Centers for Medicare & Medicaid Services, patients with two diagnoses for rheumatoid arthritis on separate dates of service during either an outpatient visit or non-acute inpatient discharge should receive at least one Disease-Modifying Anti-Rheumatic Drug (DMARD) prescription.

Anti-rheumatic medications in the BlueCross Medicare Advantage formulary include:

- Hydroxychloroquine oral tablet – Tier 2 (lowest copay)
- Leflunomide oral tablet – Tier 2 (lowest copay)
- Methotrexate sodium oral tablet – Tier 2 (lowest copay)
- Minocycline oral capsule – Tier 2 (lowest copay)
- Minocycline oral tablet – Tier 4 (higher copay)
- Minocycline oral tablet extended release – Tier 4 (higher copay)
- Sulfasalazine oral tablet – Tier 2 (lowest copay)
- Sulfazine ec oral tablet, delayed release – Tier 2 (lowest copay)

Click **Care Management Contact Information** for a comprehensive list of contacts now available on the Utilization Management page of **www.bcbst.com**.

## Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. العربية *(Arabic);* Bosanski *(Bosnian) ;* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish-Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638.

Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, or disability. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim? Call 1-800-468-9698 for BlueCare or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues. For TTY help call 771 and ask for 888-418-0008.

***** These changes will be included in the appropriate 3Q 2015 provider administration manual update.

**Archived editions of BlueAlert are available online at** http://www.bcbst.com/providers/bluealert/archive/index.page.

## †Provider Service lines

***Featuring "Touchtone" or "Voice Activated" Responses***

**Note:** If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or just say **Network Contracts or Credentialing** when prompted, to easily update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

**Commercial Lines** **1-800-924-7141**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**AccessTN/Cover Kids** **1-800-924-7141**
Monday–Friday, 8 a.m. to 6 p.m. (ET)

| | |
|---|---|
| **BlueCare** | **1-800-468-9736** |
| **TennCare*Select*** | **1-800-276-1978** |
| **CHOICES** | **1-888-747-8955** |
| **BlueCare Plus℠** | **1-800-299-1407** |
| **BlueChoice℠** | **1-866-781-3489** |
| **SelectCommunity** | **1-800-292-8196** |

Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

**BlueCard**
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**BlueAdvantage** **1-800-841-7434**
**BlueAdvantage Group** **1-800-818-0962**
Monday–Friday, 8 a.m. to 5 p.m. (ET)

***eBusiness Technical Support***
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

of Tennessee

September 2015

Bluealert SM

# BlueCross BlueShield of Tennessee, Inc.

**Applies to all lines of business unless stated otherwise**

## Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

**Effective October 10, 2015**

- Genetic Testing for Marfan Syndrome, Thoracic Aortic Aneurysms and Dissections and Related Disorders (New)
- MRI-Guided Focused Ultrasound (MRgFUS) (Revised)
- Salivary Testing for Steroid Hormone Levels (Revised)

**Effective November 18, 2015**

- Eribulin Mesylate (Revised)
- Mechanical Stretch Devices for the Treatment of Joint Stiffness (Revised)

**Note:** These effective dates also apply to BlueCare Tennessee pending State approval.

## Coming Soon…… 2015 Flu Season!

Flu season will soon rear its ugly head. It is important that you take the appropriate preventive care measures to protect your patients during this time of year. Flu season is very unpredictable and can vary in length and severity because the flu viruses constantly change. Therefore, it is important that you educate all patients or parents of children older than 6 months of age on the importance of getting a yearly flu vaccine.

**Because patients 65 and older are at greater risk for serious complications from the flu, they have the option to receive the standard vaccine or a newer higher-dose vaccine**. The higher-dose vaccine is 24 percent more effective for people in this age group according to *The New England Journal of Medicine*.

Please make every effort to schedule your patients that are high risk to get a flu shot as early as possible for the flu season. To avoid missed opportunities for vaccination, offer immunizations during routine health care visits and hospitalizations once the vaccine is available.

**The following influenza immunization and reimbursement guidelines apply for BlueCross.**

**Commercial**

- ***Vaccine and administration***
  The influenza vaccine, including intradermal and nasal-administered, is a covered benefit if offered under the member's health care plan. Verify coverage by calling our Provider Service Line†.

**BlueCare or TennCare*Select***

- ***Vaccine and administration***
  Covered benefit
- ***Nasal-administered vaccine***
  (recommended for healthy individuals ages 2 through 49)
  Covered benefit

  **Note:** The intranasal-administered quadravalent, preservative- free vaccine is available under the Tennessee Department of Health's Vaccines for Children (VFC) Program for children ages 2 through 18 years.

  For more information, call 1-800-404-3006, Monday through Friday, 8 a.m. to 4:30 p.m.
- ***Intradermal-administered vaccine***
  (recommended for persons 18 through 64 years of age)

**Note:** The intradermal-administered vaccine is not available under VFC.

**Medicare Advantage**

- ***Intradermal and nasal-administered vaccines***
  Covered benefit

## Health Care Practice Recommendations Updates

BlueCross Health Care Practice Recommendations have been updated. The *Seventh Report of the Joint National Committee on Prevention, Evaluation and Treatment of High Blood Pressure* (JNC 7) clinical practice guideline (CPG) for hypertension is now: **Managing Blood Pressure in Adults: Systematic Evidence Review From the Blood Pressure Expert Panel** (JNC 8; 2013).

This and other CPGs can be viewed in their entirety online at http://www.bcbst.com/providers/hcpr. Paper copies can be obtained by calling 1-800-924-7141, ext. 6705.

## ICD-10 Compliant Prior Authorization Requests

As a reminder, the compliance date for transitioning to ICD-10 coding is Oct.1, 2015. The following information can be used when submitting prior authorization requests:

- Prior authorization requests can now be submitted for dates of service beginning on Oct. 1, 2015. These requests should be submitted with applicable ICD-10 codes.
- Retrospective prior authorization requests for dates of service before Oct. 1, 2015, should be submitted with applicable ICD-9 codes.
- Prior authorization requests that have already been approved that span the Oct. 1 compliance date will not need to be resubmitted. BlueCross' claim matching functionality allows existing authorizations that span the compliance date to pay with claims submitted using the appropriate diagnosis version (ICD-9 or ICD-10), based on the claim dates of service to comply with the Oct. 1, 2015 implementation of ICD-10.

Additional information regarding ICD-10 implementation is available on the ICD-10 Page of our website at http://www.bcbst.com/providers/icd-10.page.

## Upcoming Changes to Provider Service Lines

BlueCross will be updating its Provider Service Phone Lines in the coming months. Please be aware that some of our prompts will be changing.

# BlueCare Tennessee

**This information applies to BlueCare and TennCare*Select* plans, excluding dual-eligible BlueCare Plus (HMO SNP)SM unless stated otherwise**

## Complete a TennCare Kids Checkup when Performing Sports Physicals

The school year is underway and many kids will need physicals before they play sports for their school. Sports physicals are the perfect opportunity to conduct a TennCare Kids checkup. To be considered a TennCare Kids checkup, the visit should include:

- Health history
- Complete unclothed physical exam
- Lab tests as needed
- Shots as needed
- Vision/hearing screening
- Developmental/behavioral screening as appropriate
- Advice on how to keep healthy

For more information about TennCare Kids checkups and billing, please refer to http://tnaap.org/coding.

## myBLUE PCP

BlueCare Tennessee encourages its members to make more informed health care choices, while directing them to receive coordinated care which starts with their assigned primary care provider (PCP). As a BlueCare Tennessee PCP, it is your responsibility to verify that the members you see are either assigned to you or another PCP in your group. PCPs will not be reimbursed for their services to members who are not assigned to them or to a covering provider.

Members are allowed to change their PCP assignment at any time by initiating a PCP change request.

The member can:

- Call customer service.
  **BlueCare: 1-800-468-9698**
  **TennCare*Select*: 1-800-263-5479**
- Fax the completed PCP Change form to 1-888-261-9025.
- Print a temporary ID card from their BlueAccessSM account at http://bluecare.bcbst.com/.

Providers can submit changes to their member rosters by:

- Faxing the completed PCP Change form to 1-888-261-9025
- Calling the Customer Service line while the member is in their office and allowing the member to speak to Customer Service to request the PCP Change

- E-mailing PCP change requests via e-mail mailbox: IO-BluecarePCP_GM@BCBST.com

## Timely Submission of Prior Authorization or Notification Request

Effective immediately, timely submission of a prior authorization request for BlueCare Tennessee members admitted into the hospital directly from the physician's office no longer requires authorization before the member arrives at the hospital. Authorization is required within 24 hours or the next business day from the admission date.
All other requirements for timely submission will remain the same including elective and emergency admissions.

# Medicare Advantage

**This information applies to BlueAdvantage℠ HMO/PPO plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise.**

## Host the BlueCross Mobile Unit On-site

The BlueCross Mobile Unit is now available for needed screenings to support gaps in care. For BlueCross Medicare Advantage members the mobile unit staff can provide information about their health benefit plan, including our partnership with SilverSneakers to help seniors remain active. They also have the opportunity to receive needed screenings like bone density, retinal eye exam, kidney function and HbA1c blood sugar screenings for diabetic patients.

As the member's attributed provider these screenings count toward quality of care measures for your practice.

To find out more about how hosting the Mobile Unit and how it can help your Medicare Advantage patients please contact Jodi Bolen at (423) 535-3765. Scheduling is subject to availability.

## Reminder: Authorization Status - Did you Know?

You can check the status of your authorization by simply logging into BlueAccess and clicking on the **"Authorization / Advance Determination Inquiry"** section from the "Service Center" link. An advantage of checking online is not only time saved but you can also print your status from the website. If you are interested in training, please contact your eBusiness Marketing Representative. Their contact information is located in the Provider Service lines† section of the newsletter.

## Online Submissions for Durable Medical Equipment Now Available

To make prior authorization requests for Durable Medical Equipment (DME) easier and more efficient for you, the BlueCross Senior Care Division is now accepting electronic submissions for DME via BlueAccess. You may submit up to 30 HCPCS Codes and up to five medical records or Certificates of Medical Necessity (CMN) (at least one medical record or CMN is necessary). For further questions on the submission process please contact eBusiness Technical Support†.

QUALITYCARE REWARDS

**This information applies to all lines of business unless stated otherwise.**

## Help Ensure Your Patients' Wellness

As a provider, you can take steps to help your patients stay healthy by recommending regular wellness exams and screenings.

The best way to beat illnesses is to prevent them before they happen. Well visits or annual exams are important aspects of overall wellness even when children, adolescents and adults are healthy. That's why it's important to schedule these visits for your patients.

Wellness exams focus on prevention. These patient encounters allow you and the patient to discuss health concerns and potential illnesses before serious issues arise. Wellness visits are also good times to evaluate health screening needs, update vaccinations, discuss medications, encourage healthy lifestyles and answer any general health questions to help your patients manage their care.

It's important to remember that well-care preventive services count towards Quality Measures, regardless of the primary intent of the visit. However, services that are specific to an acute or chronic condition do not count toward the well-care measure. To expedite claim processing remember:

- Use correct diagnosis and procedure codes.
- Submit claims and encounter data in a timely manner.

## Assure Diabetic Patients Receive Needed Screenings

Regular checkups and screenings are key to managing diabetes effectively. BlueCross makes it easy and rewarding for your Medicare Advantage patients to get the screenings they need. Your diabetic patients between the ages of 18 and 75 should receive the following screenings each year:

- Kidney Function – a free benefit that is eligible for a $15 patient reward.
- HbA1c – a free benefit that is eligible for a $15 patient reward.
- Retinal Eye Exam – a free benefit that is eligible for a $15 reward for the patient if they use our in-home vendor, and a $40 reward if they use an eye doctor
- Cholesterol (LDL) – a free benefit as part of the patient's annual wellness exam
- Blood Pressure – a free benefit as part of the patient's annual wellness exam

Medicare Advantage members can also receive most of these screenings performed in the comfort of their own home through our in-home services program. As the member's attributed provider these screenings count toward quality of care measures for your practice.

Call BlueCross to find out about the in-home services we offer for your patients.

## Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. العربية *(Arabic);* Bosanski *(Bosnian) ;* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish-Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638.

Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, or disability. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim? Call 1-800-468-9698 for BlueCare or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues. For TTY help call 771 and ask for 888-418-0008.

***** These changes will be included in the appropriate 3Q 2015 provider administration manual update.

**Archived editions of BlueAlert are available online at** http://www.bcbst.com/providers/bluealert/archive/index.page.

## IMPORTANT REMINDER

**Be sure your CAQH ProView™ profile is kept up to date at all times. We depend on this vital information.**

## †Provider Service lines

***Featuring "Touchtone" or "Voice Activated" Responses***

**Note:** If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or just say **Network Contracts or Credentialing** when prompted, to easily update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

**Commercial Lines** **1-800-924-7141**
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Friday, 9 a.m. to 5:15 p.m. (ET)

**AccessTN/Cover Kids** **1-800-924-7141**
Monday–Friday, 8 a.m. to 6 p.m. (ET)

**BlueCare** **1-800-468-9736**
**TennCare*Select*** **1-800-276-1978**
**CHOICES** **1-888-747-8955**
**BlueCare Plus℠** **1-800-299-1407**
**BlueChoice℠** **1-866-781-3489**
**SelectCommunity** **1-800-292-8196**
Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

**BlueCard**
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**BlueAdvantage** **1-800-841-7434**
**BlueAdvantage Group** **1-800-818-0962**
Monday–Friday, 8 a.m. to 5 p.m. (ET)

***eBusiness Technical Support***
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

of Tennessee

October 2015

Bluealert SM

# BlueCross BlueShield of Tennessee, Inc.

**Applies to all lines of business unless stated otherwise**

## Medical Policy updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

**Effective Nov. 14, 2015**

- Endovascular Therapies for Extracranial Vertebral Artery Disease **(New)**
- Sublingual Liquid Immunotherapy **(New)**
- Upper Limb Myoelectric Orthosis **(New)**
- Vagal Nerve Blocking Therapy for Treatment of Obesity **(New)**

**Effective Nov. 18, 2015**

- Intensity-Modulated Radiotherapy of the Breast and Lung **(New)**
- Ofatumumab **(Revision)**
- Pembrolizumab **(Revision)**

**Note:** These effective dates also apply to BlueCare /TennCare*Select* pending State approval.

## Financial Planning Tools Now Available

BlueCross BlueShield of Tennessee strongly believes in equipping our members to make the best decisions regarding their health. Financial costs are a huge determining factor when it comes to health care choices. As such, we have developed a Financial Planning Tool available in BlueAccess℠, which compares cost and quality outcomes measures, to encourage our members to make the best health decisions possible.

For more information, see our Financial Planning Tools Flier or our Financial Planning FAQs

## New Drug Added to Commercial Specialty Pharmacy Listing

Effective Oct 1, 2015, the following drug has been added to our Specialty Pharmacy drug list. Drugs requiring prior authorization are identified by (PA).

**Self-administered via pharmacy benefit:** Orkambi (PA)

Providers can obtain prior authorization for:

- **Provider-administered drugs** that have a valid HCPCS code by logging onto BlueAccess, the secure area of www.bcbst.com, selecting Service Center from the Main menu, followed by Authorization/Advance Determination Submission. If you are not registered with BlueAccess or need assistance, call eBusiness Technical Support†.
- **Provider-administered specialty drugs** that do not have a valid HCPCS code by calling 1-800-924-7141.
- **Self-administered specialty drugs** by calling Express Scripts at 1-877-916-2271.

**NOTE:** BlueCross updates web authorization forms on a quarterly basis. If the HCPCS code is not available now, it may be in the near future.

## HRA Tip

You can easily find Health Reimbursement Arrangement (HRA) information on the Patient Information page of BlueAccess at http://www.bcbst.com/ Simply log in and go to the Service Center. Click on Patient Inquiry to search for your patient. When you click on the patient's name, the Patient Information page shows all of your patient's health benefit information, including HRA information (if your patient selected this benefit option). You can also use the quick reference guide for HRA that is located in the Service Center under the Demos and Tutorials section. If you have questions or need technical support, please call eBusiness Solutions†.

## Medication Adherence for ADHD Patients

Your help is needed. Attention-deficit/hyperactivity disorder (ADHD) is the most common neurobehavioral childhood disorder. Patient response to ADHD medication can vary. That is why it is critical to schedule timely follow-up visits with patients who have been newly prescribed ADHD medication.

**What can you do?** You play an essential role in developing and ensuring patient/parent trust by offering and maintaining high quality care by:

1. **Conducting a follow-up visit within 30 days of a new prescription**. For better patient compliance, consider scheduling the appointment while the patient is in your office.

NOTE: **A lapse in prescription refill greater than 120 days** should be considered a new prescription and **requires an additional 30-day follow-up visit**. *This is more common after summer break***.**

2. When writing prescriptions for new ADHD medication therapy, consider writing only a 30-day prescription. If prescription refills are written for more than 30 days remember to schedule the two additional required follow-up appointments at the time each refill is due. After the first 30-day follow-up visit, **you can conduct one of the two continuation follow-up visits via phone consultation** as long as it is coded appropriately when billed.
3. Ask the parent what amount of medication they already have on hand if a 90-day prescription is written.
4. Provide educational materials to parents.
5. Suggest a behavioral health consultation if medication alone is not managing their child's behavior.

The adopted Clinical Practice Guideline is available through the National Institute of Mental Health (NIH) at http://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd/index.shtml.

If you feel your patient may benefit from Behavioral Health Services call the PCP Referral Line for BlueCare Tennessee members at 1-800-367-3403 or for Commercial members call 1-800-888-3773.

## Screening vs. Diagnostic Mammography

Screening mammography is provided for the early detection of breast cancer in asymptomatic women according to multiple sources, eg. AMA, AAPC, AHIMA and CMS. When a diagnostic mammogram is performed, there should be a physician's order, signs and symptoms, or a personal history warranting the procedure.

During a screening mammogram, **two** views are obtained of each breast. Although women with **elective/cosmetic** implants require at least one additional view to adequately check for abnormalities, the number of views or the presence of **cosmetic implants** does not automatically justify coding a diagnostic mammogram rather than a screening.

Billing should be based on the intent of the procedure. If the mammogram is performed for the early detection of breast cancer, the procedures should be coded as a screening. If a procedure is due to signs and symptoms of possible breast cancer, a previous abnormal screening mammogram, a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease, billing for a diagnostic mammogram would be appropriate.

## At-Home Test Kits Can Help Lower Risk for Colon Cancer

Colon cancer is the second leading cause for cancer deaths in America. It is also one of the most preventable. To help manage chronic health issues and encourage members to receive the screening, BlueCross has developed a program that will provide at-home test kits to screen for colorectal cancer. The fecal immunochemical test (FIT) kits are being offered through the Colorectal At-Home FIT Kit Program to Commercial members aged 50 to 75 years that have not received this test based on our medical claims data.

**How does it work?** In September, the identified Commercial members will receive a program introduction letter followed by a phone call inviting them to officially enroll. Those enrolled in the program will receive an at-home FIT kit (collection kit) in the mail. The kit includes instructions, supplies needed to complete the test and a postage-paid, return envelope. You can enroll our Commercial members that are lacking the test in this program by calling the Customer Service number on back of the member's ID card.

BlueCross has partnered with LabCorp who will read the tests and send the results to our members. In addition, the member's Primary Care Practitioner (PCP) will receive the lab results. We encourage you to initiate follow-up with members whose test results are positive or inconclusive.

## Reminder: Obstetric Anesthesia

Obstetric anesthesia for a planned vaginal delivery (01967) that ends in a C-Section delivery (01968) is to be billed on a single claim form using the date of delivery as the date of service. Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a standalone code on a separate claim. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code. In those cases with obstetrical anesthesia for the planned vaginal delivery beginning on one day and the actual caesarean delivery on the following day, dates of service for both codes should have the same from and through date, i.e. from beginning of anesthesia through to the completion.

Obstetric anesthesia services involving more than one Provider (e.g. two physicians or two CRNA's) for the same episode are to be submitted on a single claim with the date of delivery as the date of service.

## Reminder: Plain language

Plain language is part of a national program to encourage health care providers to promote health literacy among their patients by ensuring they **understand** written and oral health information.

Many informed consent forms and medication package inserts are written at high school level or higher, while the average patient reading level is closer to sixth grade. Most patients will not tell you they do not understand.

Using plain language allows your patients to understand their treatment plans, know how to take their prescriptions properly, and better follow your instructions. This is also important for your patients who do not speak English as their primary language. For additional information on Health Literacy, please refer to the Department of Health and Human Services website at http://www.hrsa.gov/publichealth/healthliteracy/>.

## Reminder: Flu Season Coming Soon

It is important that you take the appropriate preventive care measures to protect your patients during this time of year. Please educate all patients or parents of children older than 6 months of age on the importance of getting the yearly flu vaccine.

**Because patients 65 and older are at greater risk for serious complications from the flu, they have the option to receive the standard vaccine or a newer higher-dose vaccine**. The higher-dose vaccine is 24 percent more effective for people in this age group, according to *The New England Journal of Medicine*.

Please make every effort to schedule your high risk patients for a flu shot as early as possible to prepare for the flu season. To avoid missed opportunities for vaccination, offer immunizations during routine health care visits and hospitalizations once the vaccine is available.

The following influenza immunization and reimbursement guidelines apply to BlueCross.

**Commercial**

- ***Vaccine and administration***
  The influenza vaccine, including intradermal and nasal-administered vaccines, is a covered benefit if offered under the member's health care plan. Verify coverage by calling our Provider Service Line†.

**BlueCare or TennCare*Select***

- ***Vaccine and administration***
  Covered benefit
- ***Nasal-administered vaccine***
  (recommended for healthy individuals ages 2 through 49)
  Covered benefit

  **Note:** The intranasal-administered quadravalent, preservative- free vaccine is available under the Tennessee Department of Health's Vaccines for Children (VFC) Program for children ages 2 through 18.

  For more information, call 1-800-404-3006, Monday through Friday, 8 a.m. to 4:30 p.m. (ET).
- ***Intradermal-administered vaccine***
  (recommended for persons 18 through 64 years of age)
  Covered benefit

  **Note:** The intradermal-administered vaccine is not available under VFC.

**CoverKids**

- ***Vaccine and administration, Intradermal and nasal-administered vaccines***
  Covered benefit

**Medicare Advantage**

- ***Intradermal and nasal-administered vaccines***
  Covered benefit

## Home Health Request for Information

BlueCross BlueShield of Tennessee released a Request for Information (RFI) on Oct.1, 2015, seeking provider input, suggestions and feedback to improve quality and efficiency of home health services across all lines of business. This RFI will empower providers with information that will demonstrate their capabilities to improve members' health outcomes, increase patient satisfaction, control expenditures, and propose creative, competitive solutions for value-added services leveraging home health. The response timeline for this RFI is as follows:

| Action | 2015 Date | Time (ET) |
|---|---|---|
| RFI Issued to Providers | Oct. 1 | 9 a.m. |
| Return of intent to respond and CNDA | Oct. 9 | 5p.m. |
| Receipt of questions | Oct. 16 | 5p.m. |
| BlueCross responses to questions | Oct. 21 | 5p.m. |
| RFI response due | Oct. 30 | 5p.m. |

The RFI document is available at www.bcbst.com/providers.

## Reminder: ICD-10 Compliance Date October 1, 2015

The transition to the updated code-set occurs on Oct. 1, 2015. Check our website at http://www.bcbst.com/providers/icd-10.page for information regarding ICD-10 or email us at ICD10_GM@bcbst.com.

## High-Tech Imaging Program Changes

As of Oct. 1, 2015, you will notice a few changes to the process for submitting prior authorizations for High-Tech Imaging Services. Beginning on this date, prior authorizations should be submitted online via BlueAccess at www.bcbst.com/blueaccess. You can also submit requests by calling 1-888-693-3211 or by faxing to 1-888-693-3210.

You will find a reference guide with step-by-step instructions, on the new web submissions process available in BlueAccess. Fax forms and the code list can also be found at http://www.bcbst.com/providers/hti/.

**Please note** that during the timeframe of Oct. 1, 2015, through Dec. 31, 2015, these submissions will be limited to one CPT® code per authorization number which will increase your volume of correspondence during this time.

## Musculoskeletal Management Program Change

Beginning Nov. 1, 2015, prior authorizations for Musculoskeletal (MSK) services can be submitted online via BlueAccess at www.bcbst.com/blueaccess , via phone at 1-866-747-0586 or via fax at 1-866-747-0587. Beginning on this date, BlueCross will be partnering with OrthoNet to administer MSK management services for Commercial and MedAdvantage members.

You will find all reference materials, including a code list, fax forms and reference guide with step-by-step instructions, on the new web submissions process located within BlueAccess. Fax forms and the code list can also be found at http://www.bcbst.com/providers/utilization-management-resources.page

## Getting the Best Impression

The first person your patients usually see is your medical receptionist. The journal, *Social Science and Medicine*, published a study on their work and found receptionists are not just the "gatekeepers" or "person behind the desk." Their responsibilities often extend way beyond their administrative duties. They are a vital part of patient care.

Medical receptionists deal directly with everyone coming into your office, from patients to pharmaceutical representatives, mail men, lab couriers, etc. In addition to their administrative functions, they may confirm prescriptions with an angry patient, congratulate a new mother, console a patient whose spouse just died or help a mentally ill patient make an appointment. A significant portion of their work involves managing the emotions and care of patients and families. Medical receptionists are a key part of the relationship between patients and doctors, and patients' feelings about the receptionist may be reflected in their opinions of their doctor.

**See the latest Commercial** Code Bundling Rules **and** Professional Reimbursement Rule Indicators and RBRVS Relative Value Units (RVUs).

# BlueCare Tennessee

**This information applies to BlueCare and TennCare*Select* plans, excluding dual-eligible BlueCare Plus (HMO SNP)SM unless stated otherwise**

## Care for *Select*Kids Members Without a PCP

Since the new requirements for members to visit their assigned PCP for care went into effect Aug. 1, providers have asked questions about billing care for *Select*Kids members who do not have an assigned PCP. *Select*Kids members are only assigned to a primary care provider (PCP) after BlueCare Tennessee receives official eligibility from the Bureau of TennCare. Until these members have an assigned PCP, they may visit any TennCare*Select* or Best Practice Network (BPN) provider.

## Reminder: TENNderCare is Now Called TennCare Kids

Tennessee is committed to promoting good health in children from birth until age 21. For many years, the program was known as TENNderCare, but it's now called TennCare Kids. The only thing that has changed is the name. TennCare Kids is a full program of checkups and health care services for children who have TennCare coverage. These services make sure that babies, children, teens and young adults receive the health care they need. Good health begins at birth, so please encourage your patients/parents to check in, check-up and check back.

## Help Your TennCare Kids Patients Find a Dentist

Your TennCare Kids patients may ask or you may see a need for them to visit a dentist. DentaQuest is the dental plan for TennCare enrollees under the age of 21. If they need help finding a dentist, scheduling an appointment or assistance with any dental services, please let them know to contact DentaQuest online at http://www.dentaquest.com/ or by calling DentaQuest customer service at 1-855-418-1622. The toll-free number for the hearing impaired is TTY/TDD 1-800-466-7566.

## Online Resources for Your Patients

**TennCare Kids Connection**
Find important and helpful information about using the TennCare Kids program at http://tn.gov/tenncare/topic/tenncare-kids-connection

**KidCentral.tn**
With busy schedules, parents often find themselves out of touch with the latest updates from state departments. Invite your patients to receive twice-monthly emails from kidcentral tn. After signing up, they will receive timely, helpful news for Tennessee families.

## Laboratory Exclusions

BlueCare Tennessee has renewed their exclusive agreement with Quest Diagnostics for laboratory services with no changes to the exclusions at this time.

## TennCare's Preferred Drug List to Change October 1

TennCare is making changes to the preferred drug list (PDL), some of which will take effect Oct. 1, 2015. Some medications your patients are now taking may be non-preferred agents in the future. Please inform your patients who are on these medications that switching to preferred products will decrease delays in receiving their medications.

Click here to view a summary of PDL changes.
http://bluecare.bcbst.com/Providers/notice/Provider_Notice_for_100115.pdf

## Medication Adherence with Statins

BlueCare Plus℠ Care Coordinators are making calls to members who have been diagnosed with hyperlipidemia and have been prescribed statins but are not maintaining medication adherence to the statin. There are many factors that contribute to non-adherence, but the effect is always the same – members are putting their health at risk. We need your support in promoting member medication adherence to statins. As a health care professional, you are in a critical position to help members understand the vital role medication plays in managing a chronic condition such as hyperlipidemia.

Here are some tips on how to encourage adherence and find out if members are having trouble taking medications:

- When prescribing a new drug, explain the purpose of the medication, the name, anticipated adverse effects, frequency of administration and dosing. Have members "teach back" the information and ask questions about what they do not understand.

- Follow up with members by asking about medication adherence behavior at every visit.

Stress the effects of failing to take medications. Members respond strongly to messages about the health consequences of non-adherence, the eventual impact on their families and the value of taking control of their illness.

## Notification Requirement Change for Outpatient Physical Therapy *

As of Sept. 1, 2015, **BlueCare** and **TennCare*Select*** now require notification for the initial 12 outpatient physical therapy visits for members age 21 and older. Notification must include demographic and clinical information and indicate who will be performing the services. This information is necessary for accurate claims processing and payment. Requests for notification are not subject to prospective medical necessity review, but may be subject to retrospective review based on medical policy and medical necessity. **All** services provided by **out-of-network** providers require prior authorization. You may notify us of the initial 12 outpatient physical therapy visits by phone or by faxing the required information. Look for auto web authorization coming soon.

## Timely Submission of Prior Authorization or Notification Request*

Effective immediately, timely submission of a prior authorization request for BlueCare Tennessee and CoverKids members admitted into the hospital directly from the physician's office no longer requires authorization before the member arrives at the hospital. Authorization is required within 24 hours or the next business day from the admission date. All other requirements for timely submission will remain the same including elective and emergency admissions.

## Training for Providers of Individuals with Intellectual/Developmental Disabilities

In keeping with our commitment to provide training opportunities for Primary Care and other providers regarding the unique needs of persons with intellectual/developmental disabilities (I/DD), look for upcoming articles in *BlueAlert.* Beginning in 2016, BlueCare Tennessee will keep you informed of training opportunities available each quarter from various sources across the State.

## Reminder: Patient Billing

There are times when it may or may not be appropriate to bill your patients directly. Please refer to the *BlueCare Tennessee Provider Administrative Manual* for complete information regarding medical billing.
See also TennCare Policy PRO 08-001 at https://www.tn.gov/assets/entities/tenncare/attachments/pro08001.pdf

- Class 17 (Medicare/Medicaid dual eligible) members may **not** be billed for coinsurance and deductibles.
- Providers may **not** bill a member for services that were denied based on late claims submission.
- If a denial is based on a referral, or determination was made that there was no referral on file, the Provider may **not** bill the member or plan.
- Members may **not** be billed for services that BlueCare Tennessee does not consider medically necessary.
- Providers may **not** bill the member for charges that exceed the member's liability.
- Providers may **not** bill the member for the transfer of medical records from one provider to another provider.
- For non-emergent care, providers may only bill patients for normal TennCare co-payments.
- Providers may **not** bill members for missing a scheduled appointment.
- Providers **may** seek payment from a person whose TennCare eligibility is pending at the time services are rendered if the provider informs the person that TennCare assignment will not be accepted, whether or not eligibility is established retroactively. Providers may bill such persons at the provider's usual and customary rate for the services rendered. However, all monies collected for TennCare-covered services rendered during a period of TennCare eligibility must be refunded when a claim is submitted to TennCare if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility is established.

# Medicare Advantage

**This information applies to BlueAdvantage℠ HMO/PPO plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise.**

## Did you know? Inpatient Only Code List Available

The Medicare Advantage Inpatient Only (IPO) Code List is available on http://www.bcbst.com/providers/medicare-advantage/2015-CMS-Inpatient-Only-List.pdf. Outpatient procedures do not require authorization unless the procedure code is on the IPO list.

## Importance of Immunizations for Seniors

Our Medicare Advantage members with chronic conditions have recently received a postcard from BlueCross encouraging them to get their annual flu shot. As you know, the flu shot is a critical part of ensuring your patients stay healthy during the flu season. It is doubly important for seniors with a chronic illness who are both more susceptible and who often experience serious complications if they do get the flu.

It is also recommended that adults ages 65 and older receive both forms of the pneumococcal vaccine (PCSV23 and PCV13). Please talk with your patients about whether or not a pneumonia vaccine is right for them.

## Think Your Patients Want to Feel 25 Years Younger? Encourage Physical Activity

Researchers in Norway created a simple on line

calculator: https://www.worldfitnesslevel.org/#/
to determine fitness age and were stunned by the results. They studied participants in the United States Senior Olympics and found that older adults who are physically active have a fitness age that is 25 years younger on average than their chronologic age.

Like you, we want our members to remain independent throughout their lives. A healthy level of physical activity can help them stay that way by maintaining coordination and mental acuity, building stronger bones, promoting heart health and reducing BMI.

Please take the time to ask your patients if they have any questions about the appropriate amount of physical activity and remind them that a free SilverSneakers® gym membership is included in their BlueCross plan.

SilverSneakers® is a registered mark of Healthways, Inc. Healthways is an independent company that provides fitness services for BlueCross BlueShield of Tennessee.

## Web Submissions for Durable Medical Equipment are Now Available

To make prior authorization requests for Durable Medical Equipment (DME) more efficient and easier for you, BlueCross Senior Care Division is now accepting DME submissions via BlueAccess. You may submit up to 30 HCPCS codes and up to five attached medical records or Certificates of Medical Necessity (at least one medical record or CMN is necessary). For additional information about the submission process, please contact your eBusiness Marketing Consultant.

West Tennessee – Debbie Angner
Phone: (901) 544-2285
Email: Debbie_Anger@bcbst.com

Middle Tennessee – Faye Mangold
Phone: (423) 535-2750
Email: Faye_Mangold@bcbst.com

East Tennessee – Faith Daniel
Phone: (423) 535-6796
Email: Faith_Daniel@bcbst.com

QUALITYCARE REWARDS

**This information applies to all lines of business unless stated otherwise.**

## October is Breast Cancer Awareness Month

Women between the ages of 50 and 74 should have a mammogram every two years. For BlueCross members, this screening is included in their benefit plan at no cost to the member. Female members may also be eligible for a reward from BlueCross for having this screening. Please help us encourage your female patients who have not had the breast cancer screening to have a mammogram by the end of the year.

## Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. العربية *(Arabic);* Bosanski *(Bosnian) ;* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish-Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638.

Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, or disability. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?
Call 1-800-468-9698 for BlueCare or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues. For TTY help call 771 and ask for 888-418-0008.

***** These changes will be included in the appropriate 4Q 2015 provider administration manual update.

**Archived editions of BlueAlert are available online at**
http://www.bcbst.com/providers/newsletters/index.page?

# †Provider Service lines

***Featuring "Touchtone" or "Voice Activated" Responses***

**Note:** If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or just say **Network Contracts or Credentialing** when prompted, to easily update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

**Commercial Lines** **1-800-924-7141**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**AccessTN/Cover Kids** **1-800-924-7141**
Monday–Friday, 8 a.m. to 6 p.m. (ET)

| | |
|---|---|
| **BlueCare** | **1-800-468-9736** |
| **TennCare*Select*** | **1-800-276-1978** |
| **CHOICES** | **1-888-747-8955** |
| **BlueCare Plus℠** | **1-800-299-1407** |
| **BlueChoice℠** | **1-866-781-3489** |
| **SelectCommunity** | **1-800-292-8196** |

Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

**BlueCard**
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**BlueAdvantage** **1-800-841-7434**
**BlueAdvantage Group** **1-800-818-0962**
Monday–Friday, 8 a.m. to 5 p.m. (ET)

***eBusiness Technical Support***
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

of Tennessee

November 2015

Bluealert SM

# BlueCross BlueShield of Tennessee, Inc.

**Applies to all lines of business unless stated otherwise**

## Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

**Effective Dec. 12, 2015**

- Amniotic Membrane and Amniotic Fluid Injections (New)
- Electronic Brachytherapy for Non-melanoma Skin Cancer (New)

**Effective Dec. 16, 2015**

- BRCA1, BRCA2 and PALB2 Testing for Breast, Ovarian and Other Cancers (New)

**Note:** These effective dates also apply to BlueCare /TennCare*Select* pending State approval.

## New Prior Authorization Needed for CPT® Codes 64581 and 64590*

Starting Jan. 1, 2016, prior authorization will be required for codes 64581 and 64590 related to neurostimulator implantation for occipital nerve stimulation as well as fecal and urinary incontinence. Previously, medical records were reviewed by a nurse after claims were submitted. If the claims did not meet the appropriate guidelines, they were denied and the provider was financially liable. This new prior authorization requirement will reduce claims issues related to these codes. If you have questions, please contact the Provider Service Line†.

*CPT® is a registered trademark of the American Medical Association.*

## Dental Predetermination

We are pleased to announce that we have recently updated the form required to submit a dental predetermination request to us. These revisions were made to provide additional information in regard to any charges that are disallowed. The updated form will provide you with an improved estimation of patient responsibility and provider contractual write off. Please note this does not apply to CoverKids or BlueCare Tennessee lines of business.

## GeoBlue® offers BlueCross coverage for International Members

GeoBlue, in partnership with BlueCross BlueShield of Michigan, began serving more than 3,000 internationally based General Motors members on Jan. 1, 2015. Many of these members are enrolled in a BlueCross product, have full access to the BlueCard provider network and will present the GeoBlue identification card when seeking care in the U.S.

If a member calls for an appointment and states they have GeoBlue insurance:

- Verify eligibility and benefits by calling GeoBlue Customer Service at 1-855-282-3517 or
- Go online and verify benefits through the BlueExchange BlueCard system.
- Process claims as you would any other BlueCard claim.

GeoBlue members also have BlueDental® coverage with access to dental providers who participate in the BlueCross dental network or on a per-claim basis. To verify dental benefits, call 1-877-891-3326 and submit claims through the regular dental claims process.

## Reminder: Avoid Claim Denials by Following Prior Authorization Guidelines

Services rendered without obtaining authorization prior to services being rendered are considered "non-compliant." Prior authorization reviews can be initiated by the member, designated member advocate, practitioner or facility. However**, it is ultimately the facility and practitioner's responsibility to contact BlueCross to request an authorization**.

When a request for authorization of a procedure, an admission/service or a concurrent review of the days is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the practitioner rendering care for the day(s) or service(s) that have been denied. BlueCross's non-payment is applicable to both facility and practitioner rendering care. The member is held harmless if the member is eligible at the time services are rendered and the covered services are received from a network provider.

When prior authorization is required, providers must obtain authorization prior to scheduled services and within 24 hours or the next business day of emergent services. Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to non-compliance. **BlueCross members cannot**

**be billed for services denied due to non-compliance by the provider.**

## Help Your Patients Overcome Depression

Major depression is often excessively misdiagnosed and can lead to over prescribing of medications. The American Psychiatric Association advises that physicians only use a diagnosis of major depression if their patient has experienced at least five of the nine symptoms listed below for two weeks or more, almost every day or if their symptoms are a change from their prior level of function. Consider using alternative diagnoses for your patient's depression, such as seasonal affective disorder, bipolar disorder, situational depression or atypical depression, for your patients who do not ascribe to these symptoms.

- Depressed or irritable mood for children and adolescents
- A significantly reduced level of interest or pleasure in most or all activities
- A considerable loss or gain of weight when not dieting and/or an increase or decrease in appetite
- Difficulty falling or staying asleep or sleeping more than usual
- Agitated or slowed down behavior that others can observe
- Feelings of fatigue or diminished energy
- Thoughts of worthlessness or extreme guilt
- Reduced ability to think, concentrate or make decisions
- Frequent thoughts of death or suicide or suicide attempt

Members ages18 or older that have recently been diagnosed with major depression and are currently being treated with antidepressant medications for major depression should be encouraged to remain on their prescribed medications for at least 84 days when acute treatment is administered and for at least 180 days during periods of continuation treatment. The biggest barrier to successful treatment of depression is medication non-adherence. Members who receive extra support from their provider, such as counseling or written materials, are typically more compliant.

## Formulary Changes for Fourth Quarter

**Effective Oct. 1, 2015:**

- Tobradex ointment, TobraDex **ST** and Zylet moved to Tier 2 of BlueCross' Prescription Drug List.
- Bunavil **QL** moved to Tier 3 of BlueCross' Prescription Drug List.
- Treximet will be excluded from BlueCross' Prescription Drug List.

**ST** – Requires step therapy
**QL** – Quantity limits apply

## FDA Investigating Tramadol

The Food and Drug Administration is investigating the use of the pain medicine tramadol in children ages 17 years and younger because of the rare but serious risk of slowed or difficult breathing. This risk may be increased in children treated with tramadol for pain after surgery to remove their tonsils and/or adenoids.

Tramadol is not FDA-approved for use in children, however, data shows it is being used "off-label" in the pediatric population.The agency is asking health care providers to consider prescribing non-tramadol pain relievers for children as it completes its investigation.

## ICD-10 Compliant Updates

As of Oct. 1, 2015, all providers must comply with ICD-10 coding requirements established by the federal government. Please take note of these important updates:

- Providers are required to submit ICD-10 codes for dates of service Oct. 1, 2015, and beyond.
- Retrospective prior authorization requests for dates of service before Oct. 1, 2015, should be submitted with applicable ICD-9 codes.
- Prior authorization requests that have already been approved that span the Oct. 1 compliance date will not need to be resubmitted.
- Updated information is available on http://www.bcbst.com/providers/icd-10.page.

## Reminder: Flu Season Coming Soon

It is important that you take the appropriate preventive care measures to protect your patients during this time of year. Please educate all patients or parents of children older than 6 months of age on the importance of getting the yearly flu vaccine.

**Because patients 65 and older are at greater risk for serious complications from the flu, they have the option to receive the standard vaccine or a newer higher-dose vaccine**. The higher-dose vaccine is 24 percent more effective for people in this age group, according to *The New England Journal of Medicine*.

Please make every effort to schedule your high-risk patients for a flu shot as early as possible to prepare for the flu season.

The following influenza immunization and reimbursement guidelines apply to BlueCross.

**Commercial**

- ***Vaccine and administration***
  The influenza vaccine, including intradermal and nasal-administered vaccines, is a covered benefit if offered under the member's health care plan. Verify coverage by calling our Provider Service Line†.

**BlueCare or TennCare*Select***

- ***Vaccine and administration***
  Covered benefit
- ***Nasal-administered vaccine***
  (recommended for healthy individuals ages 2 through 49)
  Covered benefit
  **Note:** The intranasal-administered quadravalent, preservative- free vaccine is available under the Tennessee Department of Health's Vaccines for Children (VFC) Program for children ages 2 through 18.

  For more information, call 1-800-404-3006, Monday through Friday, 8 a.m. to 4:30 p.m. (ET).

- ***Intradermal-administered vaccine***
  (recommended for persons ages 18 through 64)
  Covered benefit

**Note:** The intradermal-administered vaccine is not available under VFC.

**CoverKids**

- ***Vaccine and administration, Intradermal and nasal-administered vaccines***
  Covered benefit

**Medicare Advantage**

- ***Intradermal and nasal-administered vaccines***
  Covered benefit

## Behavioral Health Network Update

Effective Jan. 1, 2016, BlueCross will assume responsibility for contracting and credentialing behavioral health providers for Medicare Advantage and Commercial lines of business.

Behavioral health providers should have already received necessary contracting documents for participation in the BlueCross behavioral health network.

Under the terms of the provider contract with Magellan, behavioral health providers who are not contracted and credentialed directly with BlueCross by Jan. 1, 2016, are required to continue seeing BlueCross members for 120 days following the Jan. 1 effective date or until members are safely transitioned to participating providers, if less than 120 days. Non-participating providers will be paid at their Magellan contracted rates until the 120 day cut off, when reimbursements will adhere to non-participating rates and increased member payment liability. Visit http://www.bcbst.com/providers/Behavioral-Health-Network.page or contact your behavioral health network manager with any questions.

## Reminder: High-Tech Imaging Program Changes

On Oct. 1, 2015, you noticed a few changes to the process for submitting prior authorization requests for High-Tech Imaging Services. Beginning on this date, all online prior authorizations must be submitted via BlueAccess℠ at www.bcbst.com/blueaccess. You can also request prior authorization for these services by calling 1-888-693-3211 or by faxing to 1-888-693-3210. Fax forms and the code list are available at http://www.bcbst.com/providers/hti/.

All reference materials including a reference guide with step-by-step instructions on the new web submissions process are located within BlueAccess.

**Please note** that during the timeframe of Oct. 1 to Dec. 31, 2015, these submissions will be limited to one CPT® code per authorization number which will increase your volume of correspondence during this time.

*CPT® is a registered trademark of the American Medical Association.*

## Reminder: Musculoskeletal Management Program Change

Beginning Nov. 1, 2015, prior authorizations for Musculoskeletal (MSK) services can be submitted online via BlueAccess at www.bcbst.com/blueaccess, via phone at 1-866-747-0586 or via fax at 1-866-747-0587. Beginning on this date, BlueCross will be partnering with OrthoNet who will administer MSK management services for Commercial and Medicare Advantage members.

You will find all reference materials, including a code list, fax forms and reference guide with step-by-step instructions, on the new web submissions process located within BlueAccess. Fax forms and the code list can also be found at http://www.bcbst.com/providers/utilization-management-resources.page

## Marketplace Open Enrollment Begins Nov. 1

Open enrollment on the Health Insurance Marketplace runs from Nov. 1, 2015 through Jan. 31, 2016. Tennesseans seeking health insurance can learn more through local community meetings and special events. More information is available on our website.

## Disease Management Program Transitioning to New Care Model

New for 2016, BlueCross will transition to a new care model integrating care management, disease management and wellness. More details on our holistic approach for members will be coming soon.

# BlueCare Tennessee

**This information applies to BlueCare and TennCare*Select* plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise**

## Improving Childhood and Adolescent Immunizations is our Top Priority.

**The Vaccines for Children Program (VFC) will benefit members and your practice, excluding CoverKids lines of business.**

**Why should I join VFC?**

- Being a VFC provider is a sound investment in your practice and in your patients.
- VFC reduces your up-front costs because you will not have to pay to purchase vaccines for VFC-eligible children.
- You can charge an administrative fee to offset your costs of doing business.
- Your patients benefit since they will not go elsewhere for the vaccines they need and there is no charge to you, the provider.

**Who is Eligible?**

- Medicaid eligible
- Uninsured
- American Indian or Alaska Native
- Underinsured: Underinsured means your patient has health insurance, but it won't cover the vaccine(s)
- **VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed**.

The VCF Program, Patient Eligibility Screening form is available on www.tn.gov./

**How do I become a VFC provider?**
Contact a VFC Quality Coordinator at (615) 741-7507 to request a Provider Enrollment Package. More information about becoming a VCF Provider is available on the CDC website.

**Correct Coding of VCF is Critical**

- It is very important that coding of vaccines for children is accurate. Please use the correct CPT® codes along with the vaccine procedure code.
- Promote the importance of vaccinations that protect our children from serious but preventable illnesses.

Source:
http://www.cdc.gov/vaccines/programs/vfc/providers/questions/qa-join.html

*CPT® is a registered trademark of the American Medical Association.*

## Updated Physician Quality Information Available

The bi-annual update to Physician Quality Information will be available on Nov. 10, 2015, for private physician review on our secure BlueAccess web portal. Physicians have a 60-day review period, during which they can submit self-report information at member level to help improve their ratings. After the 60-day review period, provider ratings will be updated to reflect the self-reported submissions. The updated provider ratings are also included in our provider directories that are available on our company website for our members.

## DME & Home Health Requests Move Solely to BlueAccess Jan. 1

BlueAccess offers you the ability to serve members by making requests for Durable Medical Equipment (DME) and home health services at any time day or night through BlueAccess, our secure provider portal. Beginning Jan. 1, 2016, BlueAccess will be the required method to submit DME and home health service requests.

BlueAccess can reduce time on the phone and eliminate the need to fax requests. You can also use BlueAccess to find benefit information, claim status, claim estimates and many other self-service resources. If you would like your office staff to learn more about using our online services, our eBusiness staff is available to provide on-site training. For more information, call eBusiness Technical Support†.

## Filing Observation Charges with Outpatient Surgery

Outpatient surgery all-inclusive rates include up to six hours of post-surgery observation time. Additional observation charges (revenue code 0762) may not be billed unless the member's time in observation is longer than six hours. This charge will be allowed if the surgery claim also includes a claim for the observation room charge.

When multiple surgeries are filed on the same claim form with observation, the highest level code is reimbursed at 100 percent of the outpatient surgery fee schedule. Each additional surgical code is reimbursed at 50 percent of the outpatient surgery fee schedule. The highest level code is not determined by the greatest total charge, but by the highest allowed.

## BlueCare Tennessee and CoverKids Payment Error Rate Measurement Program

The Centers for Medicare & Medicaid Services (CMS) will be performing an audit of BlueCare Tennessee and CoverKids providers' medical records as part of the Payment Error Rate Measurement (PERM) program. The PERM program measures improper payments made by Medicaid and the Children's Health Insurance Program (CHIP/CoverKids). CMS will review a random sample of payments with original dates of payment from Oct. 1, 2015 through Sept. 30, 2016. Medical record requests for the PERM review will begin in first quarter 2016.

## Tennessee Health Care Innovation Initiative

Tennessee Health Care Innovation Initiative (THCII) November reports will be available by Nov. 7. To review your November THCII reports, please log into BlueAccess at **www.bcbst.com** by clicking the Log In/Register link at the top right corner of the page. If you have not registered for BlueAccess, the link will guide you through registration.

Wave 1 BlueCare, TennCare*Select* and CoverKids Episode of Care reports for Asthma Exacerbation, Perinatal care and Total Joint Replacement (hip and knee) are currently in the Performance Period which runs from Jan.1 to Dec. 31, 2015. Gain or Risk Sharing will be applied to providers after the 2015 calendar year has ended.

Wave 2 Episode of Care reports for Acute COPD Exacerbation, Screening and Surveillance Colonoscopy, Cholecystectomy, and Acute and Non-Acute PCI are Preview Reports intended to provide information regarding your performance against quality and efficiency measures. The November reports also include thresholds for these Episodes of Care. BlueCare, TennCare*Select* and CoverKids Wave 2 Episodes of Care will move into the Performance Period on Jan. 1, 2016 and will reflect all Episodes of Care which end in the 2016 calendar year, with Gain or Risk Sharing applied in 2017.

The Wave 2 THCII BlueCare Contract Amendments will be mailed to BlueCare contracted acute care facilities, cardiologists, gastroenterologists, general surgeons and colon and rectal surgeons in early November 2015. If you are a BlueCare contracted provider in one of these specialties and do not receive an amendment, please contact your Network Manager. If you do not know who your network manager is, you can find them by using the My BlueCross Contact tool at **www.bcbst.com/providers/mycontact/?nav=calltoaction**.

For more information about the THCII Episodes of Care, visit the State of Tennessee website at **www.tn.gov/hcfa/section/strategic-planning-and-innovation-group**

## National Drug Code Claim Filing

The Deficit Reduction Act (DRA) of 2005 required states to collect rebates on provider-administered drugs. Providers must include the National Drug Code (NDC) of the drug(s) administered, along

with the correct quantity and unit, for all provider-administered drugs for medical claims filed on a CMS-1500 Health Insurance Claim form or submitted electronically in the ANSI-837 version 5010 format and facilities filing outpatient UB claims on a CMS-1450 claim form or submitted electronically in the ANSI-837 Institutional version format with exceptions of vaccines and inpatient claims.

All other Providers should submit claims with the NDC information for "J" codes only. Any missing element may result in the claim being returned unprocessed. Please refer to the Provider Administration Manual for all data elements required. http://www.bcbst.com/providers/manuals/BCT_PAM.pdf

## Provider Satisfaction Survey

We are listening and your input is valuable to us. An online Provider Satisfaction Survey is now on the BlueCare Plus℠ website at: https://www.bcbst.com/forms/anon/org/app/9c4d4280-dc57-45e0-8dd9-f6a97e09de50/launch/index.html?form=F_Form1. The survey offers providers another opportunity to submit suggestions, ideas and opportunities and to rate your experience with BlueCare Plus**.** Visit us today!

# Medicare Advantage

**This information applies to BlueAdvantage℠ HMO/PPO plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise.**

## Notification Approval for Home Health Allows up to Seven Visits in One Month

To allow time for home health agencies to complete all documentation required by the Centers for Medicare & Medicaid Services (CMS) without a delay in patient care, BlueAdvantage allows up to a maximum of seven visits over a one-month period when home health requests are submitted for notification in a timely manner. This notification approval will allow for the initial evaluation and treatment plus six additional visits without any care management review. If more than seven visits are needed, or the timeframe exceeds one month, additional medical management review will be necessary with required clinical documentation to support the request.

## Oxygen Authorizations Now Limited to a Calendar Year

Beginning Jan. 1, 2016, BlueAdvantage members will no longer receive lifetime, or multi-year approval for oxygen equipment rentals.

Because plan benefits can change at the beginning of each calendar year, a new authorization will be required at the beginning of the new year and will be valid for a maximum of 12 months.

If an authorization is approved during the year, it will remain in effect through the end of the calendar year and need to be re-certified for continued approval in the new year.

The annual request will need a certification of medical necessity completed by the requesting physician and dated within two months of the request. Please remember, oxygen rental is only covered for 36 months in accordance with CMS regulations.

## Reminder: Refer Lab Work to a Participating Provider

Providers are reminded to use in-network options for all laboratory services requested for BlueAdvantage members, unless the specific laboratory test is not available from a participating lab provider. This includes genetic testing that is covered by Medicare. If the provider refers testing to a non-participating lab and the test was available through a participating provider, the cost may be the provider's, not the member's, responsibility through reconciliation.

QUALITYCARE REWARDS

**This information applies to all lines of business unless stated otherwise.**

## Diabetes Measures that Can Affect Your Quality Score

November is American Diabetes Month and a good opportunity to take a few minutes to make sure you are aware of the various quality measures the Centers for Medicare & Medicaid Services (CMS) has in place that can affect your quality score.

According to CMS, everyone between the ages of 18 and 75 with a diagnosis of diabetes should receive the following each year:

- HbA1c blood test
- Diabetic retinal eye exam
- Kidney function screening

BlueAdvantage and BlueChoice members should be reminded they may be eligible for a reward from BlueCross for each of these services they complete.

We understand sometimes it can be hard to get elderly members into your office. That's why we offer in-home services for each of these diabetic screenings. Our health partners can mail kits to your diabetic patients for HbA1c, kidney function screenings and schedule in-home eye exams, as well. And if you are the member's attributed provider, you get the quality credit for the service.

## Schedule a Bone Density Test for Blue Advantage members within Six Months of a Fracture

As you know, often the first symptom of osteoporosis in an older person is a broken bone. Because seniors, especially senior women, are susceptible to osteoporosis, it is important to schedule a bone density test for those who have suffered a fracture.

Best Practices

- Encourage your patients to include adequate amounts of calcium in their diets.

- Recommend regular weight-bearing exercise like walking or dancing.
- Talk to your patients about risk factors for falls.
- Measure height annually.
- Perform a bone mineral density test on women 65 and older and men 70 and older.
- Prescribe appropriate medication for patients with a documented hip or vertebral fracture.

## Reminder: BlueAdvantage In-Home Test Kits Available for Homebound Members

BlueCross now offers in-home test kits for three of the most common annual screenings. With a simple phone call, our partner, Home Access can mail our BlueAdvantage and BlueChoice members an in-home test kit for:

- Fecal occult blood screening for colorectal cancer
- Kidney function screening for diabetic patients
- HbA1c blood test for diabetic patients

Following the instructions, the member then mails the kit back to the vendor for lab testing and the written results are then sent to the member and you. The screenings are at no cost to the member and count toward the member's quality rewards incentive for attributed members.

For more information on how to order an in-home test kit for members, contact Julie Mason at (423) 535-6827.

## At-Home Test Kits Now available for Commercial members too!

Colon cancer is the second leading cause for cancer deaths in America. It is also one of the most preventable. To help manage chronic health issues and encourage members to receive colorectal cancer screenings, BlueCross will provide at-home test kits to screen for the disease. Fecal immunochemical test (FIT) kits are being offered through the Colorectal At-Home FIT Kit Program to commercial members ages 50 to 75 that have not received this test based on our medical claims data.

Qualifying commercial members received a program introduction letter and a phone call in September inviting them to officially enroll in the FIT kit program. Those enrolled in the program will receive an at-home FIT kit (collection kit) in the mail. The kit includes instructions, supplies needed to complete the test and a postage-paid return envelope. Providers can also enroll qualifying BlueCross Commercial members.

Members' and primary care practitioners will receive the lab results we then encourage you to initiate follow-up with members whose test results are positive or inconclusive.

**BlueCross BlueShield of Tennessee offices will be closed November 26 and 27, 2015 in observance of Thanksgiving.**


## Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. العربية *(Arabic);* Bosanski *(Bosnian) ;* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish-Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638.

Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, or disability. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

Call 1-800-468-9698 for BlueCare or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues. For TTY help call 771 and ask for 888-418-0008.

***** These changes will be included in the appropriate 4Q 2015 provider administration manual update.

**Archived editions of BlueAlert are available online at** http://www.bcbst.com/providers/newsletters/index.page?

## †Provider Service lines

***Featuring "Touchtone" or "Voice Activated" Responses***

**Note:** If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or just say **Network Contracts or Credentialing** when prompted, to easily update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

**Commercial Lines 1-800-924-7141**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**AccessTN/CoverKids 1-800-924-7141**
Monday–Friday, 8 a.m. to 6 p.m. (ET)

| | |
|---|---|
| **BlueCare** | **1-800-468-9736** |
| **TennCare*Select*** | **1-800-276-1978** |
| **CHOICES** | **1-888-747-8955** |
| **BlueCare Plus℠** | **1-800-299-1407** |
| **BlueChoice℠** | **1-866-781-3489** |
| **SelectCommunity** | **1-800-292-8196** |

Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

**BlueCard**

| | |
|---|---|
| Benefits & Eligibility | **1-800-676-2583** |
| All other inquiries | **1-800-705-0391** |

Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

| | |
|---|---|
| **BlueAdvantage** | **1-800-841-7434** |
| **BlueAdvantage Group** | **1-800-818-0962** |

Monday–Friday, 8 a.m. to 5 p.m. (ET)

***eBusiness Technical Support***
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

of Tennessee

December 2015

Bluealert SM

# BlueCross BlueShield of Tennessee, Inc.

**Applies to all lines of business unless stated otherwise**

## Medical Policy Updates/Changes

The BlueCross BlueShield of Tennessee Medical Policy Manual has been updated to reflect the following policies. The full text of the policies listed below can be accessed at http://www.bcbst.com/providers/mpm.shtml under the "Upcoming Medical Policies" link.

**Effective Jan. 9, 2016**

- **Breast Reconstructive and Symmetry Surgery Following Mastectomy (Revised)**
- **Urinary Metabolite Tests for Adherence to Direct-Acting Antiviral Medications for Hepatitis C (New)**

**Note:** These effective dates also apply to BlueCare /TennCare*Select* pending State approval.

## Clinical Practice Guidelines (Health Care Practice Recommendations) Updates

BlueCross Health Care Practice Recommendations have been updated to include two new behavioral health recommendations:

- The American Psychiatric Association's *Practice Guideline for the Treatment of Patients with Substance Use Disorders, Second Edition (2006) and Guideline Watch (April 2007)* and
- *Practice Guideline for the Treatment of Patients with Eating Disorders, Third Edition (2006) and Guideline Watch (August 2012).*

These and other updates can be viewed in their entirety on the company website. Paper copies of any clinical practice guideline can be obtained by calling 1-800-924-7141, ext. 6705.

## HealthCare Cost Estimator Now Available

BlueCross BlueShield of Tennessee strongly believes in equipping our members to make the best decisions regarding their health. Financial costs are a huge determining factor when it comes to health care choices. As such, we have developed a HealthCare Cost Estimator, which compares cost and quality outcomes measures, available in BlueAccess℠ to encourage our members to make the best health decisions possible.

For more information, see our HealthCare Cost Estimator flier or our HealthCare Cost Estimator FAQs.

## Dental Coding Changes*

Per the current guidelines set by the American Dental Association (ADA), the following CDT® codes will be deleted as of Jan. 1, 2016: D0260, D0421, D2970, D9220, D9221, D9241, D9242 and D9931.

The following CDT® codes will be added as of Jan. 1, 2016, and will be covered under the standard DentalBlue contract: D4283, D4285, D5221, D5222, D5223, D5224, D9223** and D9243**.

** D9223 will replace D9220 and D9221 and D9243 will replace D9241and D9242. Anesthesia for dental will now be filed in 15 minute increments so it will be important to file with the correct code and time beginning Jan. 1, 2016.

If a deleted code is filed beginning with date of services Jan. 1, 2016, or after, that line item will not be processed and you will be advised to refile with the most current ADA code. For questions, contact Dental Customer Service at 1-800-523-1478.



## New Care Model for 2016

New for 2016, BlueCross BlueShield of Tennessee will transition to a new care model integrating care management,

disease management, behavioral health and wellness. This new holistic approach to population health management addresses health needs along the entire continuum of care through condition-specific outreach and targeted interventions. The goal is to improve and maintain the physical and psychosocial well-being of members through tailored solutions integrating care management, disease management, behavioral health and wellness.

## Mandate 386: Group Contracts

In accordance with the Public Chapter No. 386 Mandate, a series of law changes from the State of Tennessee, BlueCross BlueShield of Tennessee will be adjusting notification requirements for new providers seeking to join **existing contracted provider groups**.

Effective Jan. 1, 2016, BlueCross will notify providers seeking to join existing groups of key information, including:

- All information and documentation required for a credentialing application
- Credentialing status within five days of receiving a completed application

*To initiate the credentialing process, contracted provider groups must contact BlueCross Provider Network Services at 1-800-924-7141 and request to add new providers.*

Additional updates regarding this change will be forthcoming.

## CMS Changes Guidelines and Rates for Hospice Providers*

The Centers for Medicare & Medicaid Services (CMS) recently changed their guidelines and rates for outpatient hospice services. Some of the rate changes were effective Oct. 1, 2015, and other changes will not be implemented until Jan. 1, 2016. BlueCare and TennCare*Select* networks, including CoverKids, will follow the CMS rate guidelines and effective dates. For commercial networks P, S, E and M, all CMS changes will be effective Jan. 1, 2016.

The most significant change separates the reimbursement for routine home care (RHC) into two rate levels. RHC services delivered during the first sixty (60) days of care will be paid at one level, while services provided **after** sixty (60) days will be reimbursed at a lower level. To help ensure your claims are paid appropriately, make sure you file the correct admission date on your claim submissions.

Additionally, Medicare created a Service Intensity Add-On payment for social worker or RN visits during the member's last seven (7) days of life. This additional payment is only eligible when billed in conjunction with RHC services. To receive the add-on payments, claims must include the appropriate discharge status. For details about the rate changes, please see the information from CMS.

**NOTE:** ***These guidelines and rate changes do not apply for services to Medicare Advantage members.***

## Reminder: OrthoNet Services for Musculoskeletal (MSK) Program

OrthoNet began administering the following musculoskeletal (MSK) management services Nov. 1 for BlueCross BlueShield of Tennessee's Commercial and Medicare Advantage members:

- Pain Management
- Spinal Surgery (Medicare Advantage Care Management previously reviewed these codes)
- Joint Surgery (Hip, Knee and Shoulder)
- Physical Medicine (Physical Therapy, Occupational Therapy and Chiropractic) **Medicare Advantage Only**

Authorization requests can be submitted online via BlueAccess at www.bcbst.com/blueaccess, via phone at 1-866-747-0586 or via fax at 1-866-747-0587.

You can find all reference materials, including a code list, fax forms and reference guide with step-by-step instructions on the new web submissions process located within BlueAccess. You can also find fax forms and the code list at http://www.bcbst.com/providers/utilization-management-resources.page.

## New and Revised Place of Service Codes (POS) for Outpatient Hospital

Beginning Jan. 1, 2016 **t**he Centers for Medicare & Medicaid Services (CMS) is making the following changes to the current POS code set:

- A new **POS code 19** for "Off Campus-Outpatient Hospital" is being added.
- **POS code 22** is being changed from "Outpatient Hospital" to "On Campus-Outpatient Hospital."

Claims for covered services rendered in an Off Campus-Outpatient Hospital setting, or in an On Campus-Outpatient Hospital setting will both pay at the facility rate. The payment policies for POS 22 will continue to apply and will also apply to POS19 unless otherwise stated.

These new CMS guidelines will apply to all lines of BlueCross business. To

ensure your claims are paid accurately, please make sure you file the correct POS Codes on your claim submissions.

## Update: BlueCross Behavioral Health Network

The transition from Magellan to BlueCross BlueShield of Tennessee's internal network is on track to be effective Jan. 1, 2016. On this date, BlueCross will assume responsibility for contracting and credentialing behavioral health providers for Medicare Advantage and Commercial lines of business. Arrangements have already been made to ensure members receive appropriate and necessary care during this transition.

In conjunction with assuming credentialing and contracting responsibilities for behavior health, BlueCross will implement MCG® Behavioral Health Care Guidelines to ensure accurate and timely care for covered members.

To learn more about the BlueCross behavioral health network and MCG guidelines, visit http://www.bcbst.com/providers/Behavioral-Health-Network.page.

## Opiate Medication Added to 2016 Quantity Limitation (QL) Drug List

To prevent accidental or intentional overuse of prescription drugs, BlueCross places a quantity limit on select formulary drugs. For 2016, additional opiate medications are being added to the QL Drug List. These quantities are considered reasonable amounts and provide a safety margin for prescribing practitioners.

More detailed information on BlueCross' Commercial formularies and the Quantity Limitation Drug List can be found at: https://www.bcbst.com/docs/pharmacy/2016_Whats_Changing_Prescription_Drug_List.pdf
Exceptions to the quantity limits can be requested 24/7 by calling 1-877-916-2271.

## Reminder: Physician Quality Information Application Available until Jan. 11, 2016

The Physician Quality Information Application on BlueAccess will be available for physician review and self-reporting until Jan. 11, 2016. After Jan. 11, provider ratings will be updated to reflect the self-reported submissions and the updated provider ratings will be included in our provider directories that are available on the company website for our members.

## Utilization Management Update: Discharge Dates

Discharge dates play an integral role in claims processing and BlueCross BlueShield of Tennessee quality assurance initiatives. Once a patient is discharged from a provider's care, BlueCross care transition and case management staff contact the patient to identify post-discharge gaps, such as home care needs and required follow-up appointments. This process helps reduce patient readmission and improves overall care, but confirmation of discharge is required for this to take place.

Currently, the process for confirming a patient discharge requires a telephone call between BlueCross and the provider office to gather key information. While necessary, this process is inefficient and misuses key resources, most notably the time required to complete telephone calls.

Soon, BlueCross will transition to a more streamlined discharge data collection process by establishing a dedicated fax number for this information. Faxing discharge information will cut down on processing times, ensure patients gain access to all necessary recovery and post-discharge resources as quickly as possible and help reduce unnecessary readmissions.

More information on this transition will be announced in the coming weeks.

## Submit Hospice Requests Online Through BlueAccess

As of Nov. 1, 2015, BlueCross Commercial and BlueCare Tennessee providers can submit hospice requests online through BlueAccess. Our secure provider portal minimizes phone time, eliminates the need for handling fax submissions and ensures requests can be submitted for all services 24 hours-a-day, 7 days-a-week. Benefit information, claim status, claim estimates and many other self-service resources are also available through BlueAccess. The eBusiness Solutions team can help you with BlueAccess registration and provide onsite training. For more information, contact the eBusiness Service Center by calling (423) 535-5717 and selecting option 2, or via email at eBusiness_service@bcbst.com.

## REMINDER: In-network Care Teams

Our members get the most from their health benefits when they receive care from participating network providers. As one of our network providers, please remember your contractual obligation to ensure our members only receive care from BlueCross-contracted providers. This includes inpatient or hospital-based care and is especially

important in the event of emergency surgery or other emergent care events. Our "Find a Doctor" tool on bcbst.com can be used to easily locate other participating network providers.

## Reminder: New Prior Authorization Needed for CPT® Codes 64581 and 64590

Starting Jan. 1, 2016, prior authorization will be required for codes 64581 and 64590 that are related to neurostimulator implantation for occipital nerve stimulation as well as fecal and urinary incontinence, for Commercial lines of business.

Previously, medical records were reviewed by a nurse after claims were submitted. If the claims did not meet the appropriate guidelines, they were denied and the provider was financially liable. This new prior authorization requirement will reduce claims issues related to these codes. If you have questions, please contact the Provider Service Line†.

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# BlueCare Tennessee

**This information applies to BlueCare and TennCare*Select* plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise**

## BlueCare Tennessee to Target Abuse of Painkillers

Over the last 10 years, Tennessee has seen drastic increases in the number of opioids prescribed, the rate of opioid addiction treatment admissions, incidences of opioid related fatalities and cases of neonatal abstinence syndrome. Tennessee ranks second in the nation for opioid overdose deaths. Only diabetes, pneumonia and the flu cause more deaths each year statewide. Beyond these unnecessary deaths, many others in Tennessee suffer from the effects of opioid abuse and addiction.

BlueCare Tennessee wants to help change this by working with providers in our network to prevent the abuse and unnecessary deaths associated with these prescriptions. BlueCross has partnered with Axial Healthcare to help providers see how their prescribing patterns compare to others in the state. BlueCare Tennessee will soon begin contacting health care professionals whose prescribing patterns are significantly beyond normal patterns. Axial will also schedule educational visits with some providers to help them to adjust their prescribing patterns to align more with clinical norms.

You can look forward to more information about this initiative in the future.

## Is Your List of Medical Emergency Diagnosis Codes Up-to-Date?

While ICD-10 coding requirements became live Oct. 1, 2015, BlueCare Tennessee and CoverKids continue to receive many medical emergency claims that have incorrect or out-of-date diagnosis codes. These errors most often result in a denied claim that has to be refiled, a situation that neither side wants. Using the ICD-10 diagnosis codes is the best way to ensure your claims are processed quickly and accurately.

It may also be helpful to know which ICD-10 condition codes are considered medical emergencies by BlueCare Tennessee including CoverKids. The most up-to-date list of medical emergency codes is available at bluecare.bcbst.com.

## Reminder: BlueCare Tennessee and CoverKids Payment Error Rate Measurement (PERM) Program

The Centers for Medicare & Medicaid Services (CMS) will be performing an audit of BlueCare Tennessee and CoverKids providers' medical records as part of the PERM program. The PERM program measures improper payments made by Medicaid and the Children's Health Insurance Program (CHIP). CMS will review a random sample of payments with original dates of payment from Oct. 1, 2015, through Sept. 30, 2016. Medical record requests for the PERM review will begin in first quarter 2016.

## TennCare Provider Registration

Whether you are a new provider to TennCare/Medicaid or an existing TennCare/Medicaid provider, you will need to register your information here. TennCare is now using web-based technology to simplify and improve the provider registration/re-verification process. Individual providers only need to register once to be added to the TennCare CAQH roster.
Once your registration is approved, you will receive a TennCare/Medicaid ID number. A valid TennCare/Medicaid ID number is required for participation in TennCare and is required to:

1. Submit Medicare/Medicaid "cross-over" claims to TennCare for consideration of Medicare copays and deductibles for our members with Medicare as a primary carrier.
2. Contract with any TennCare Managed Care Organization in order to provide medically necessary services to TennCare members.
3. Receive payments from TennCare's EHR Incentive Program.

For more information, please visit the TennCare Provider Registration Website

## Follow NPI Provider Usage Rules for Submitting CoverKids Claims

When your office is submitting claims for CoverKids members, please ensure they comply with National Provider Identifier (NPI) requirements.

These guidelines apply to electronic claims submitted in the 5010 format, as well as claims submitted on CMS-1450 and CMS-1500 paper claim forms. Submitting claims without the proper information could delay your reimbursement payments.

## DME & Home Health Requests Move Solely to BlueAccess Jan. 1

BlueAccess offers you the ability to serve members by making requests for durable medical equipment (DME) and home health services at any time day or night through BlueAccess, our secure provider portal. Beginning Jan. 1, 2016, BlueAccess will be the required method to submit DME and home health service requests.

BlueAccess can reduce time on the phone and eliminate the need to fax requests. You can also use BlueAccess to find benefit information, claim status, claim estimates and many other self-service resources. If you would like your office staff to learn more about using our online services, our eBusiness staff is available to provide on-site training. For more information, call eBusiness Technical Support†.

## Reporting Critical Incidents for BlueCare Tennessee Members

If you have employees who provide home health care to BlueCare or TennCare*Select* members, your employees must report any significant incident they discover to BlueCare Tennessee. **A critical incident report must be filed within 24 hours of discovery.**

**Significant events include:**

- **Unexpected death**
- **Abuse – Known/Suspected:** physical, mental or sexual – infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish
  **Neglect – Known/Suspected:** - A lack of care that could potentially lead to harm to the member.
- **Major/Severe Injury:** An injury that requires assessment and treatment beyond basic first aid that can be administered by a lay person
- **Safety Issues:** Situations where the member is at risk for harm:
  - Falls
  - Lack or no continuity of care
  - Home health agency staff operating outside scope of practice and/or plan of care regardless if the member was or was not harmed
  - Environmental situations not conducive to member condition
- **Exploitation:** Unauthorized, improper or failure to use the member's funds, property or other resources according to the member's desires or well-being

Each incident must be reported to BlueCare Tennessee within 24 hours of discovery using the Home Health Agency Critical Incident Reporting form.
Completed forms or questions should be faxed to:

**BlueCare Quality of Care Oversight Department**
**Fax: 1-855-339-3022**

A member of the BlueCare Tennessee Quality of Care Oversight Department will be in contact regarding any additional documentation that is needed.

In addition to reporting home health critical incidents to BlueCare Tennessee, home health agencies should always follow reporting requirements to Adult Protective Services or Child Protective Services.

## National Drug Code for CoverKids Claim Filing

The Deficit Reduction Act (DRA) of 2005 requires states to collect rebates on provider-administered drugs. This also applies to CoverKids claims. CoverKids claims must include the National Drug Code (NDC) of the drug(s) administered, along with the quantity and unit. This applies to:

- Provider-administered drugs for medical claims filed on a CMS-1500 Health Insurance Claim form or submitted electronically in the ANSI-837 version 5010 format
- Facilities filing Outpatient UB claims on a CMS-1450 claim form or submitted electronically in the ANSI-837 Institutional version format with exceptions of Vaccines and Inpatient Claims
- All other Providers should submit claims with the NDC information for "J" codes only.

Please note, submitting claims without the proper information could delay your reimbursement payments.

If you have questions about the data elements required, you can find them in the *BlueCare Tennessee Provider Administration Manual*.

## Sterilization Consent Form Update

The Bureau of TennCare received approval from the Centers for Medicare & Medicaid Services (CMS) to continue to use the current Sterilization Consent Form. This form is available on the state's website at the following link https://tn.gov/tenncare/topic/miscellaneous-provider-forms.

## Reminder: Provider Satisfaction Survey

We are listening and your input is valuable to us. A BlueCare Plus℠ Provider Satisfaction Survey is now available on our website. The survey offers providers another opportunity to submit suggestions, ideas and opportunities to rate your experience with BlueCare Plus. Visit us today!

# Medicare Advantage

**This information applies to BlueAdvantage℠ HMO/PPO plans, excluding dual-eligible BlueCare Plus (HMO SNP)℠ unless stated otherwise.**

## A Healthy New Year Starts with an Annual Wellness Exam

BlueCross' member reward and incentive program, My Healthpath®, will continue to focus on better health outcomes in 2016 with an added push to help ensure each BlueAdvantage and BlueChoice (HMO)℠ member receives an annual wellness exam.

In 2016, an annual wellness exam will be required for returning members to receive the various incentives for tests like colorectal cancer screening and mammograms. For your patients to earn those rewards, a claim for an annual wellness visit with either a G438 or G0439 code must be filed. These codes will trigger the member's eligibility for any of the incentives they can receive in 2016.

**Note:** An incentive for the annual wellness exam itself will be available to existing patients, as well as patients new to our BlueAdvantage or BlueChoice℠ plans. Patients must be returning members to one of BlueCross' Medicare Advantage plans to receive the additional incentives.

## Fall Prevention Key to High Quality of Life for Seniors

One out of three older adults falls each year, and many older adults don't know they have balance problems because symptoms are often mild or seem unrelated. Because even a minor fall can be serious, please take a moment to talk to your patients about fall prevention and what they can do to make sure their homes are safe environments.

**Fall prevention tips:**

- Removing loose rugs from the floor
- Adding non-skid surfaces in the shower
- Removing clutter, especially in hallways
- Moving electrical cords that run across the floor
- Maintaining good lighting, especially in stairwells and halls
- Installing handrails near the toilet, tub and stairways
- Moving things on high shelves to lower ones
- Wearing shoes in the house instead of slippers or bare feet

## Guidelines for Submitting a Provider Assessment Form – Medicare Advantage

In 2016, physicians will again be eligible to receive payments for completing and submitting a Provider Assessment Form for their attributed BlueAdvantage and BlueChoice members.

BlueAdvantage will reimburse the service as E/M Code 99420 with a maximum allowable charge of:

- $250 for dates of service between Jan. 1 and March 31, 2016
- $200 for dates of service between April 1 and June 30, 2016
- $175 for dates of service between July 1 and Sept. 31, 2016
- $150 for dates of service between Oct. 1 and Dec. 31, 2016

To receive reimbursement, you must complete the form and submit electronically via BlueAccess or complete the fillable Provider Assessment Form and submit via fax to 1-877-922-2963. The form should also be included in your patient's chart as part of his or her permanent record. For additional information about the Provider Assessment Form, please visit: http://www.bcbst.com/providers/quality-initiatives.page

## Oxygen Authorizations Now Limited to a Calendar Year

Beginning Jan. 1, 2016, BlueAdvantage members will no longer receive lifetime or multi-year approval for oxygen equipment rentals. Because plan benefits can change at the beginning of each calendar year, a new authorization will be required at the beginning of the new year and be valid for a maximum of 12 months. If an authorization is approved during the year, it will remain in effect through the end of the calendar year and will need to be re-certified for continued approval in the new year.

The annual request will need a certification of medical necessity completed by the requesting physician and dated within 2 months of the request. Please remember, oxygen

equipment rental is only covered for 36 months according to CMS regulations.

## BlueCross Offers BlueAdvantage and BlueChoice Members In-Home Health Assessments

To comply with CMS risk adjustment and HEDIS requirements, BlueCross BlueShield of Tennessee, in partnership with CenseoHealth, arranges voluntary, in-home, health assessments for a portion of our Medicare Advantage membership. The health assessment program is intended to collect data, not provide treatment and should not interfere with care administered by the member's physician. A key aspect of the program is encouraging routine appointments with the member's primary care provider (PCP) for wellness and maintenance check-ups. Once the assessment is complete, a summary of findings is sent to the PCP of record.

Any questions regarding this program may be directed to your provider relations consultant or BlueCross' Provider Service Line, 1-800-841-7434.

QUALITYCARE REWARDS

**This information applies to all lines of business unless stated otherwise.**

## Tobacco Cessation

As a BlueCross BlueShield of Tennessee provider, you have the opportunity to encourage our members to improve their health by quitting smoking. You can provide vital support by discussing tobacco cessation with members and directing members to support resources.
Follow these tips to help patients kick the nicotine habit:

- Engage patients in a conversation about quitting.
- Discuss over-the-counter cessation aids and determine if medications may be beneficial.
- **DO NOT** promote the use of e-cigarettes as smoking-cessation aids.
- Direct patients to the Tennessee Tobacco Quitline at 1-800-Quit-Now or www.tnquitline.com for cessation support or counseling resources.

If you have questions about member eligibility for smoking cessation services, log in to BlueAccess to confirm coverage.

## Reminder: Avoidance of Antibiotic Treatment in Adults and Children with Respiratory Conditions

BlueCross is committed to providing physicians with important information that supports appropriate testing and antibiotic use. This quality improvement initiative focuses on the **avoidance of antibiotic treatment** in children and adults with the following respiratory conditions.

- Children (ages three (3) months to 18 years) with upper respiratory infection (URI)
- Children (ages two (2) to 18 years) with pharyngitis (CWP), except for children who test positive for strep.
- Adults (ages 18 to 64 years) with acute bronchitis (AAB)

**If you find that your patient has a bacterial infection, remember to use ICD-10 codes specific to bacterial infections.**

BlueCross would like to partner with our physicians on this important initiative to work collaboratively to improve quality measurements for antibiotic prescribing and decreasing antibiotic resistance. Educational information is available on our websites as well as on the Centers for Disease Control and Prevention (CDC) website at www.cdc.gov/getsmart.

## Remind Your Patients of Importance of Flu Shots

All children under the age of 2 years need to receive at least **2 influenza (flu) immunizations by 23 months of age** and patients ages **2 years and older need to be immunized against the flu every year**. **Remember, patients 65 years and older are at greater risk for serious complications from flu a**nd almost 90 percent of flu-related deaths happen in patients older than 65, along with nearly 60 percent of hospitalizations. To avoid missed opportunities for vaccination:

- Consider offering vaccinations during routine health care visits.
- Offer patients vaccines during hospitalizations when the flu vaccine is available.
- Offer flu shot only appointments if your practice is able.
- Consider offering extended office hours and/or Saturday office hours so your patients can come in after work or on an off day to get their flu shot.

You are your patient's best protection against the flu, and we appreciate all you do to protect the health of our members!

## Do you need help in another language? ¿Habla español y necesita ayuda con esta carta?

Llámenos gratis al BlueCare 1-800-468-9698. Llámenos gratis al TennCare*Select* 1-800-263-5479. العربية *(Arabic);* Bosanski *(Bosnian);* کوردی — بادینانی *(Kurdish-Badinani);* کوردی — سۆرانی *(Kurdish- Sorani);* Soomaali *(Somali);* Ngươi Việt *(Vietnamese);* Español *(Spanish)* call 1-800-758-1638. Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, religion, national origin, or disability. Need help due to health, mental health or learning problem, or disability; or do you need to report a different treatment claim?

Call 1-800-468-9698 for BlueCare or 1-800-263-5479 for TennCare*Select* to report discrimination compliance issues. For TTY help call 771 and ask for 888-418-0008.

***** These changes will be included in the appropriate 4Q 2015 provider administration manual update.

**Archived editions of BlueAlert are available online at** http://www.bcbst.com/providers/newsletters/index.page?

**BlueCross BlueShield of Tennessee Offices will be closed December 24 & 25, 2015 for the Christmas holiday**

## †Provider Service lines

***Featuring "Touchtone" or "Voice Activated" Responses***

**Note:** If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, and choose the "touchtone" option or just say **Network Contracts or Credentialing** when prompted, to easily update your information; **and**
- Update your Provider profile on the CAQH Proview™ website.

**Commercial Lines 1-800-924-7141**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

**AccessTN/CoverKids 1-800-924-7141**
Monday–Friday, 8 a.m. to 6 p.m. (ET)

| | |
|---|---|
| **BlueCare** | **1-800-468-9736** |
| **TennCare*Select*** | **1-800-276-1978** |
| **CHOICES** | **1-888-747-8955** |
| **BlueCare Plus℠** | **1-800-299-1407** |
| **BlueChoice℠** | **1-866-781-3489** |
| **SelectCommunity** | **1-800-292-8196** |

Available Monday–Friday, 8 a.m. to 6 p.m. (ET)

**BlueCard**
Benefits & Eligibility **1-800-676-2583**
All other inquiries **1-800-705-0391**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)

| | |
|---|---|
| **BlueAdvantage** | **1-800-841-7434** |
| **BlueAdvantage Group** | **1-800-818-0962** |

Monday–Friday, 8 a.m. to 5 p.m. (ET)

***eBusiness Technical Support***
Phone: Select Option 2 at **(423) 535-5717**
e-mail: **eBusiness_service@bcbst.com**
Monday–Thursday, 8 a.m. to 5:15 p.m. (ET)
Friday, 9 a.m. to 5:15 p.m. (ET)